

2016

Grounded theory examination of the perspective of practice and education sectors regarding graduate registered nurse practice readiness in the Australian context

May El Haddad

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**Grounded Theory Examination of the
Perspective of Practice and Education Sectors
Regarding Graduate Registered Nurse Practice
Readiness in the Australian Context**

**This thesis is submitted
in fulfilment of the requirements for the degree of**

DOCTOR OF PHILOSOPHY

University of Wollongong

By

May El Haddad RN, BSN, Master of Nursing (Honours)

2016

ABSTRACT

Despite the considerable reform in nursing education and graduate transition programmes and the commitment of academics to prepare competent registered nurses (RNs), the debate regarding graduate RN practice readiness continues to linger. Such debate is in part reflective of a difference in opinion between nurses in education and practice sectors, as to whether recently graduated RNs are in fact practice ready. In order to understand this longstanding debate, a Grounded Theory study was undertaken. The study explored the perspectives of nurse unit managers (NUMs) as representatives of the practice sector and Bachelor of Nursing programme coordinators (BNPCs) as representatives of the education sector regarding newly graduated RN practice readiness within the Australian context. The process of theoretical sampling; theoretical saturation; theoretical sensitivity; constant comparative analysis; open, selective and theoretical coding; and memoing were utilised. Semi-structured interviews were undertaken with sixteen BNPCs and NUMs from across the country. NVivo™ (version 9) was used to manage the significant volume of data and to facilitate the process of data analysis and coding.

The research resulted in the conceptual emergence of the substantive theory ***Practice Readiness: A Nebulous Construct***, which explains how practice readiness, as it relates to newly graduated RNs in the Australian context, is viewed through different lenses in the practice and education sectors. The theory elucidates how participants' epistemological dissonance due to contextual influences that are pragmatic and are shaped by their **Inhabiting Disparate Realities**, serve to perpetuate the longstanding debate that recently graduated RNs are not practice ready.

It is anticipated that the findings from this study will inform a national debate and discussion regarding the nursing curricula, the nature of partnerships between the education and practice sectors, and the nature of what is expected of novice graduate RNs within practice settings. This new knowledge has the scope to enhance the transition experiences of newly graduated RNs and as such enhance their retention in the workforce. Additionally, this will translate to the delivery of cost effective, high quality healthcare in Australia.

THESIS CERTIFICATION

CERTIFICATION

I, May El Haddad, declare that this thesis, submitted in fulfilment of the requirements for the award of Doctor of Philosophy, in the School of Nursing, Faculty of Science, Medicine and Health, University of Wollongong, is wholly my own work unless otherwise referenced or acknowledged. The document has not been submitted for qualifications at any other academic institution.

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(Signature)

May El Haddad

Date: 17th July 2016

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DEDICATION

This thesis is dedicated to my late father, Mounir and to my husband and soulmate, Sean.

ACKNOWLEDGEMENTS

Undertaking a PhD candidature and writing this thesis is not a solitary activity and would not have been possible without the support and contribution of many people. Firstly, I acknowledge the contribution of the participants of this study who willingly gave their time and shared their insights and opinions by participating in this research.

I wish to thank my co-supervisor Dr Marc Broadbent, who initially encouraged me to apply for my candidature. I had considered pursuing such an academic journey following a promise I made my late father many years ago. Marc's encouragement helped me realise that now was the time to embark on this journey and his ongoing support has been invaluable.

My sincere gratitude also goes to my principal supervisor, Professor Lorna Moxham for her support, supervision and guidance throughout my candidature. Lorna's wealth of knowledge, expertise, professionalism and commitment enabled me to navigate through the obstacles of my PhD journey. Lorna was always available to take my calls and reply to my e-mails, providing a steady source of encouragement and motivation.

I wish to acknowledge the beautiful friendship and support I received from my study colleagues Alison and Carina, who tirelessly shared the highs and lows of this journey. Our friendly conversations helped me understand the nuances of grounded theory and enabled me to stay focused. I also thank Dr Fay Haisley for proof reading my thesis and for her positive feedback.

Of course none of this would have eventuated if it was not for the ongoing support of my family and friends. I am indebted to them for being patient and understanding and for showing interest in my research. In addition, I wish to thank all my professional colleagues at the Sunshine Coast Hospital and Health Service for their support and encouragement during my candidature.

Finally, I would like to express my greatest gratitude to my husband Sean for allowing me to indulge in this process. Your love and your unwavering support and understanding have made it easier for me to fulfil my dream.

AWARDS, PUBLICATIONS AND PRESENTATIONS

Emanating from and informed by this research

Awards

Awarded the *Director's General Encouragement Award*: **El Haddad, M** 2011 'Building clinical placement capacity and capability - the team based clinical facilitation model', a poster presentation to the 4th *Passionate about Practice Conference*, Brisbane, 8-9 August.

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Barnes, M, Andersen, P, **El Haddad, M**, Oakley, M, Murray, D, Hirst, K, Collins, F & Wallis, M 2015, 'Development, implementation and evaluation of a dedicated education unit across two aged care settings in the Sunshine Coast region', (Vol. \$24,514), *Queensland Clinical Education and Training Council (QCETC)*.

Henderson, A, Barnes, M, Rowe, J, **El Haddad, M**, McMillan, J, Hirst, K & Slade, C 2015, 'Developing and piloting a nursing and midwifery clinical skills learning framework to enhance student learning across industry and academic learning spaces', (Vol. \$9,659.00), *Learning and Teaching Grant, University of Sunshine Coast*.

Peer reviewed publications

El Haddad, M, Moxham, L & Broadbent, M 2013, 'Graduate registered nurse practice readiness in the Australian context: An issue worthy of discussion', *Collegian*, vol. 20, pp. 233-238.

Non peer reviewed publications

El Haddad, M 2011, 'Building clinical placement capacity: the journey of a regional health service district in Queensland', unpublished report commissioned by *Clinical Education Queensland (ClinEdQ)*, Brisbane.

El Haddad, M 2012, 'Concerns over graduate job readiness', invited interview with the editor of the *Nursing Review*, which has a readership of approximately 33,000 nurses across Australia.

El Haddad, M 2014, 'Ready or not', *Nursing Review*, issue 4, pp. 32-33.

Invited speaker

El Haddad, M 2012, 'Building capacity of placements through a revised clinical facilitation model', paper presented to the *Innovation in Clinical Placements – Coordinating and Improving Access to Clinical Education Conference*, Melbourne, 21-22 March.

El Haddad, M 2013, 'Building clinical placement capacity', paper presented to the meeting of *Queensland Youth Industry Links and Sunshine Coast Health Placement Innovation Group*, Sunshine Coast, Queensland, 5 June.

El Haddad, M, Moxham, L & Broadbent, M 2013, 'Practice ready for what? The meaning of graduate RNs' practice readiness', paper presented to the *Association of Queensland Nurse Leaders Conference*, Brisbane, 23-25 October.

El Haddad, M, Moxham, L & Broadbent, M 2014, 'Graduate RN practice readiness', a webinar presentation to the *Nurses For Nurses Network*, Australia, 8 May.

Peer reviewed conference presentations

El Haddad, M 2011, 'Building clinical placement capacity through a revised clinical facilitation model', paper presented to the *Thinking Aloud, Thinking Ahead Australasian Nurse Educators Conference*, Hamilton, 23-25 November.

El Haddad, M, Moxham, L & Broadbent, M 2012, 'Towards an understanding of graduate registered nurses' practice readiness', paper presented to the *14th National Nurse Education Conference*, Perth, 11-13 April.

El Haddad, M, Moxham, L & Broadbent, M 2013, 'Practice ready for what? Graduate RN practice readiness', paper presented to the *ICN 25th Quadrennial Congress*, Melbourne, 18-23 May.

El Haddad, M, Moxham, L & Broadbent, M 2013, 'Graduate RN practice readiness', paper presented to the *ACN Conference: Success through Synergy*, Canberra, 21 October.

El Haddad, M 2014, 'Clinical placement modelling – Success through synergy', paper presented at the *National Nurse Education Conference*, Adelaide, 2 May.

El Haddad, M, Moxham, L & Broadbent, M 2015, 'Graduate RN practice readiness': Practice ready for what?', paper presented to the *World Congress on Nursing*, Dubai, 23-25 November.

Peer reviewed conference poster presentations

El Haddad, M 2011, 'Building clinical placement capacity and capability - the team based clinical facilitation model', poster presented to the *4th Passionate About Practice Conference*, Brisbane, 8 -9 August.

El Haddad, M 2011, 'The RN education: the application to clinical practice', poster presented to the *Thinking Aloud, Thinking Ahead Australasian Nurse Educators Conference*, Hamilton, 23-25 November.

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GLOSSARY OF KEY TERMS

ACRONYM	TERM	MEANING
	Acute hospital setting	Public and private hospitals that provide treatment or care to patients for a condition requiring immediate care or intervention, where the average length of stay is relatively short (Department of Health and Aging 2009a).
AIN	Assistant In Nursing	Assistants in Nursing work as members of the nursing team, assisting registered and endorsed nurses and supporting patients in their activities of daily living. For example, helping patients with their hygiene needs and assisting nurses monitor their condition by taking blood pressure, temperature and respiration rates.
ABS	Australian Bureau of Statistics	The Australian Bureau of Statistics is Australia's official statistical organisation. The ABS assists and encourages informed decision-making, research and discussion within governments and the community, by leading a high quality, objective and responsive national statistical service.
AHPRA	Australian Health Practitioner Regulation Agency	The organisation responsible for the implementation of the National Registration and Accreditation Scheme (NRAS) for health practitioners in Australia. AHPRA supports the National Health Practitioner Boards, such as the Nursing and Midwifery Board of Australia (NMBA) in implementing the scheme (ANMAC 2012).

ACRONYM	TERM	MEANING
AIHW	Australian Institute of Health and Welfare	The Australian Institute of Health and Welfare is a major national information and statistics agency that provides authoritative information and statistics on Australia's health and welfare. AIHW is an independent statutory agency in the Health and Ageing portfolio (AIHW 2013a).
ANMAC	Australian Nursing and Midwifery Accreditation Council	The independent accrediting authority for nursing and midwifery under the National Registration and Accreditation Scheme (NRAS). ANMAC sets standards for accreditation and accredits nursing and midwifery programmes leading to registration and endorsement (ANMAC 2012).
ANMC	Australian Nursing and Midwifery Council	Before Australia's National Registration and Accreditation Scheme (NRAS), ANMC was the peak body for the nursing and midwifery professions. The ANMC authored the original set of Accreditation Standards as well as the National Competency Standards for nursing and midwifery in Australia before it evolved into the accrediting authority for nursing and midwifery (ANMAC) on 1 July 2010, under the NRAS.
BN Programme	Bachelor of Nursing Programme	The full programme of study and experiences that is required to be undertaken to become a registered nurse in Australia (ANMC 2007). For the purpose of this study, all ANMAC approved programmes leading to registration as a registered nurse will be referred to as BN programmes.

ACRONYM	TERM	MEANING
BNPC	Bachelor of Nursing Programme Coordinator	Also known as Head of Programme. Responsibilities include academic leadership, academic quality, curriculum development and delivery, together with alignment of the learning outcomes, learning activities and assessments of the BN programme (University of the Sunshine Coast 2014).
	Clinical Placement	All BN programmes offer off-campus clinical experience time, which is also referred to as clinical placement. Clinical placements offer students opportunities to interact with real patients and healthcare providers. This is where students are expected to apply learned knowledge and skills in a real practice environment thus enabling them to build their confidence and develop their professional identity.
	Clinical Facilitator	An experienced registered nurse who is employed by the education provider or the health service provider to engage in work-based supervision with nursing students in a one-to-small group structured relationship while on student placement.
	Clinical Role	The main role in a clinical nurse's job. It applies to a registered or enrolled nurse who is mainly involved in the care and treatment of patients, as well as the supervision and management of clinical nurses (AIHW 2013a).
	Competence	The combination of skills, knowledge, values and abilities that underpin effective and/or superior performance in a profession/occupational area (NMBA 2006).

ACRONYM	TERM	MEANING
CDNM	Council of Deans of Nursing and Midwifery	The peak organisation that represents the Deans and Head of Schools of Nursing and Midwifery that offer undergraduate and postgraduate programmes in nursing and midwifery throughout Australia and New Zealand.
COAG	Council of Australian Governments	The peak intergovernmental forum in Australia, comprising the Prime Minister, state premiers, territory chief ministers and the president of the Australian Local Government Association.
	Education provider	A university responsible for delivering education programmes of study, the graduates of which are eligible to apply to the Nursing and Midwifery Board of Australia for nursing registration (ANMAC 2012).
EN	Enrolled Nurse	A person registered to provide nursing care under the direct or indirect supervision of a registered nurse (NMBA 2016).
HWA	Health Workforce Australia	An initiative of the Council of Australian Governments, which was established to meet the challenges of providing a health workforce able to respond to the needs of the Australian community (ANMAC 2012).
HEI	Higher Education Institution	Tertiary education provider who meets the Higher Education Standards Framework (Threshold Standards) as prescribed by the Tertiary Education Quality and Standards Agency Act 2011 and is currently registered with the Tertiary Education Quality and Standards Agency (ANMAC 2012).

ACRONYM	TERM	MEANING
	National Competency Standards for the RN	Core competency standards by which performance and professional conduct is assessed to obtain and retain registration as a registered nurse in Australia (NMBA 2006). First published by the ANMC in 2006 and adopted by the NMBA at the start of the National Registration and Accreditation Scheme in 2010. Recently reviewed and are replaced by the <i>Registered Nurse Standards for Practice</i> in February 2016, which will take effect on 1 st June 2016 (NMBA 2016).
NRAS	National Registration and Accreditation Scheme	The Australian National Registration and Accreditation Scheme commenced on 1 July 2010.
NMBA	Nursing and Midwifery Board of Australia	The national body responsible for the regulation of nurses and midwives in Australia.
NUM	Nurse Unit Manager	Also known as the Charge Nurse. The NUM is a registered nurse with responsibility for a ward, unit or team and plays a key management and leadership role to ensure the achievement of quality patient outcomes (ANF 2003).
	Preceptor	A registered nurse who is nominated to provide work-based supervision to nursing students on student placement in a one-to-one relationship.

ACRONYM	TERM	MEANING
RN	Registered Nurse	‘A person who has completed the prescribed education preparation, demonstrates competence to practice and is registered under the Health Practitioner Regulation National Law as a registered nurse in Australia’ (NMBA 2016, p. 6).
	System drivers	In this thesis, system drivers relate to monetary and regulatory processes and standards that govern both the practice and education sectors at macro level i.e. curricula composition/requirements and accreditation standards (ANMAC 2012; NMBA 2006, 2016) and at micro level i.e. skill-mix at unit/ward level and budget requirements.

CHAPTER ONE

RESEARCH OVERVIEW

Introduction

Studying in an Australian Bachelor of Nursing (BN) programme provides opportunities to develop knowledge and skills in the area of nursing at a beginning practitioner level that can be applied in many contexts (Moxham 2015). According to the Australian Nursing and Midwifery Accreditation Council (ANMAC 2012), Australian universities are charged with the responsibility of ensuring newly graduated registered nurses (RNs) have the required knowledge, skills, attitudes and behaviours to meet the *National Competency Standards for the Registered Nurse* (Nursing and Midwifery Board of Australia [NMBA] 2006). With the awarding of registration, newly graduated RNs are expected to be competent to practice safely and effectively as they commence nursing practice (NMBA 2006) but notably, at a novice level (McGrath et al. 2006). However, an analysis of the literature reveals a spirited, longstanding debate indicating a difference in opinion between nurses in education and practice sectors, as to whether recently graduated RNs are in fact practice ready (Greenwood 2000; Rush et al. 2015; Watt & Pascoe 2013; Wolff, Pesut & Regan 2010). Much of this debate surrounds the issue of the supposed theory-practice gap (Clark & Holmes 2007; Evans, Boxer & Sanber 2008; Monaghan 2015).

Despite the commitment of academics to prepare competent RNs, the debate regarding newly graduated RN practice readiness continues to linger in Australia (Cubit & Ryan 2011; De Bellis et al. 2001; El Haddad, Moxham & Broadbent 2013; Evans, Boxer & Sanber 2008; Hinton & Chrigwin 2010; Kenny et al. 2012; Mannix, Wilkes & Luck 2009; Newton & McKenna 2007; Parker et al. 2014; Watt & Pascoe 2013). Further to this, the debate also occurs in:

- Canada (Duchscher 2009; Duchscher & Myrick 2008; Romyn et al. 2009; Rush et al. 2015; Wolff, Pesut & Regan 2010)
- New Zealand (Adlam, Dotchin & Hayward 2009; Horsburgh 1989; Tuohy 2011)
- Norway (Wangensteen, Johansson & Nordstrom 2008)
- Sweden (Lofmark, Smide & Wikblad 2006)
- Turkey (Sönmez & Yildirim 2016)
- United Kingdom (Bradshaw & Merriman 2008; Brown & Edelmann 2000; Burke et al. 2014; Clark & Holmes 2007; Gerrish 2000; Glen 2009; Mabon & Macleod-Clark 1998; Monaghan 2015; Ross & Clifford 2002; Whitehead & Holmes 2011)
- United States of America (Benner 2012; Berkow et al. 2009; Casner-Lotto & Barrington 2006; Cheeks & Dunn 2010; Del Bueno 2005; Halfer & Graf 2006; Hickey 2009; Kramer 1974; Oermann et al. 2010; Spector et al. 2015; Symes et al. 2005; Williams et al. 2014; Winfield, Melo & Myrick 2009).

In order to understand this longstanding debate, exploring the perspective of both the education and practice sectors in Australia regarding newly graduated RN practice readiness is warranted.

This thesis depicts the outcomes of a Grounded Theory study. The aim of which was to explore the perspective of nurse unit managers (NUMs) as representatives of the practice sector and Bachelor of Nursing programme coordinators (BNPCs) as representatives of the education sector regarding newly graduated RN practice readiness within the Australian context.

This chapter sets the scene for the forthcoming thesis. It presents the impetus for the study, identifies the research purpose and the research aim. In addition, the research question, the organisation of the thesis and conventions used are also offered. Each of these sections is now elucidated in greater detail.

Impetus for the Study

This research arose from the researcher's professional and research interests. At the time of commencing her doctoral studies, the researcher was working as a nurse educator coordinating undergraduate nursing clinical placements and the graduate RN programme at a large regional health service in Queensland, Australia. The researcher had worked as a nurse educator within the healthcare industry and the education sector for over eighteen years in Australia and overseas. Undergraduate nursing education and graduate RN transition programmes became an increasingly significant focus of the researcher's professional role over the last sixteen years. During this time, the researcher was

often subjected to the views of senior clinicians, claiming that '*graduates are not able to hit the floor running. I wonder how they've been educated*'. The researcher was also subjected to the views of academics who claimed that they are doing what they were tasked to do, that is to '*prepare novice but safe registered nurses who can work in multiple clinical contexts*'. Furthermore, the researcher was cognisant of the local, national and international debate relating to undergraduate nursing education and conjecture regarding newly graduated RN practice readiness. This longstanding debate highlights the apparent difference in opinion between the education and practice sectors as to whether newly graduated RNs are, in fact, practice ready. Driven by the need to understand the reasons for such enduring tension and longstanding debate set in motion the impetus for the study. To this end the researcher's interest and role, which is important to describe in qualitative research (Grbich 1999) are illuminated in greater detail in *Chapter Three*.

Research Purpose

The purpose of this research, like all doctoral studies, is to contribute new knowledge to an identified gap in understanding (Schneider et al. 2013). Grounded Theory research aims to explore social patterns within human interaction and to generate comprehensive explanations of a social phenomenon of interest (Gibson & Hartman 2014; Glaser & Strauss 1967; Stern & Porr 2011; Strauss & Corbin 2008; Urquhart 2013). Such an exploration leads to the development of a substantive theory, grounded in reality through the data being

investigated (Gibson & Hartman 2014; Glaser & Strauss 1967; Stern & Porr 2011; Strauss & Corbin 2008; Urquhart 2013).

In this study, the social phenomenon being investigated is the perspectives of NUMs and BNPCs regarding newly graduated RN practice readiness in the Australian context. Given that there has been no explanation to why this debate has been longstanding, the researcher wished to understand what NUMs and BNPCs had to say about the issue. By investigating this phenomenon of interest, the researcher aspired to develop a substantive theory that explains the reason why this debate has been ongoing despite the multiple reforms undertaken nationally and internationally over the past 20-30 years in nursing education and in graduate transition programmes.

Research Aim

To better understand the apparent longstanding difference in opinion between health education and practice sectors as to whether newly graduated RNs are practice ready, the aim of this research was:

To explore the perspective of NUMs and BNPCs regarding newly graduated RN practice readiness.

Findings from this study provide insights into the factors that shape the understanding of education and practice sectors in Australia regarding newly graduated RN practice readiness.

Research Question

Glaser (1992, p. 22) asserts that grounded theorists should move into an area of interest ‘with the abstract wonderment of what is going on that is an issue and how it is handled’. Aiming to remain true to this Glaserian principle, the researcher approached the area of interest with an openness and ‘abstract wonderment’ (Glaser 1992, p. 22). This was achieved by ensuring the research question that guided data collection for this study remained broad.

In order to guide the inquiry, the following overarching research question guided the study:

‘What is the perspective of NUMs and BNPCs regarding the practice readiness of the newly graduated registered nurse’?

Organisation of the Thesis

After the usual administrative conventions, this thesis begins with a *Glossary of Key Terms*. These are provided to ensure the reader is aware of the meaning of nomenclature used. What follows thereafter is a thesis of six chapters, appendices and references.

Chapter One provides an overview of the study. It includes the research purpose, research aim, research question, and the conventions used to enhance the readability of this thesis. Engagement with the literature is presented in *Chapter Two*. This engagement confirms the gap that exists within the literature and provides the rationale as to why this area is worthy of investigation. The review

concedes that the plethora of debate signifies the importance of this study and also that the research has not previously been undertaken. *Chapter Two* also provides background information in relation to the history of nursing education in Australia. Such a historical and contemporary understanding of the context sets the scene for the study.

Chapter Three details the research design and methodology of choice. Namely, it describes in detail Grounded Theory. This chapter also presents the research methods used that led to the generation of the substantive theory ***Practice Readiness: A Nebulous Construct***. The research findings are then presented in *Chapter Four*. In this chapter the overarching substantive theory, core category, categories and associated sub-categories that informed the theory are described. These findings are then comprehensively discussed in the context of the relevant literature in *Chapter Five*. Recommendations for consideration by peak nursing professional and industrial bodies, and nurse leaders in the education and practice sectors are presented in *Chapter Six*. This final chapter also outlines the limitations of the study and offers suggestions for further research. It concludes with a final reflection from the researcher.

Conventions used throughout this Thesis

To facilitate the readability of this thesis, the following conventions are adhered to:

- **P 2 (NUM)**: Notations of this nature at the beginning of participant quotes refer to the participant group and the interview number in the series of

interviews. In this example, this would be the second interview in the series of interviews conducted with a nurse unit manager.

- **P 10 (BNPC):** Similarly such notation refers to the tenth interview in the series of interviews, which was conducted with a Bachelor of Nursing programme coordinator.
- *italic text indented*: used for long quotations in the text, quotations from interviews and also for titles of papers and significant documents.
- []: used by the researcher when clarification is inserted into quotes to improve understanding.
- ‘single quotation marks’: used for direct in-text quotations.
- ***Bold, Italic and Capitalise Each Word***: used for the name of the substantive theory.
- **Bold and Capitalise Each Word**: used for the name of the core category.
- **Bold and sentence case**: used for the name of the categories and their associated sub-categories.

It is hoped that using different font styles helps the reader identify each concept level within the thesis.

Throughout this thesis, the researcher is referred to in the third person. Acronyms for regularly used terms such as registered nurse (RN), nurse unit manager (NUM) and Bachelor of Nursing programme coordinator (BNPC) are used. At times though, these terms are written in full to emphasise the importance of the statement and to further assist the readability of the thesis.

Chapter Summary

This chapter has introduced the social phenomenon of interest, namely, the perspective of NUMs and BNPCs regarding graduate RN practice readiness in the Australian context. In addition, the reader was briefly introduced to the impetus for the study. The research purpose, research aim, research question, and conventions used were also discussed in the chapter.

Chapter Two will now present the research background. This chapter sets the scene and places the thesis in context and as such, highlights the significance of the study.

CHAPTER TWO

RESEARCH BACKGROUND AND SIGNIFICANCE

Introduction

Graduate RN transition to practice appears to remain a difficult time for newly graduated RNs (Cubit & Ryan 2011; Parker et al. 2014; Phillips, Esterman & Kenny 2015). The notion of practice readiness or perceived lack thereof is thought to pose a major challenge to industry in terms of meeting health service provider needs (Berkow et al. 2009; Clark & Holmes 2007; Evans, Boxer & Sanber 2008; Marks-Maran et al. 2013; Missen et al. 2016; Monaghan 2015). As alluded to in *Chapter One*, perceptions appear to differ between academics and clinicians in Australia and internationally as to whether recently graduated RNs are in fact practice ready (Missen et al. 2016; Rush et al. 2015; Watt & Pascoe 2013; Wolff, Pesut & Regan 2010). Given that both education and practice sectors take part in the debate, exploring both perspectives contributes an in-depth understanding to the area of interest. Within these sectors, NUMs and BNPCs are significant players.

The aim of this chapter then, is to set the scene and place the inquiry in context. To achieve this, the chapter presents significant background information. This includes information on the aging Australian population and its impact on the nursing workforce; the historical transformation in nursing education; and

national and international discourse related to practice readiness. This background information enables the reader to understand the context of this inquiry.

The chapter begins with a brief discussion regarding the significance of the research followed by the methodological rationale for conducting a cursory review of the literature in the preliminary stage. As with all chapters presented in this thesis, it will conclude with a summary of the key points.

Research Significance

Given the researcher's familiarity with contemporary national and international discourse related to graduate RNs' practice readiness, and based on a preliminary analysis of the literature, as per Grounded Theory methodology (Glaser 1998; Glaser & Strauss 1967) it was evident that opinions differed as to whether recently graduated RNs were considered practice ready (Missen et al. 2016; Rush et al. 2015; Watt & Pascoe 2013; Wolff, Pesut & Regan 2010). Contributing to this debate were workforce and professional issues, which add a level of complexity. These issues include:

- The forecasted nursing shortage (Health Workforce Australia [HWA] 2012a)
- The difficulties in accessing sufficient quality clinical placements for nursing students (Council of Deans of Nursing and Midwifery [CDNM] 2005; HWA 2012b; National Health Workforce Taskforce 2009a; PhillipsKPA 2008; Watson, M 2006)

- The wide sweeping budget cuts and inability of hundreds of graduate RNs in Australia to secure employment each year (White 2013) and,
- The community expectation of health services to provide high quality healthcare (Francis 2013; Twigg, Duffield & Evans 2013).

These issues will be explored along with other background information. These are presented to provide the reader with a contextual basis for the research.

The Use of Literature in Grounded Theory Research

It is widely recognised that the extent and timing of the use of literature in Grounded Theory is one of the most contentious and misunderstood aspects of this research methodology (Birks & Mills 2011; Charmaz 2006). This contention has primarily focused on the use of literature in the initial stages of inquiry. Glaser and Strauss (1967) and Glaser's later work (1998) argue that a formal review of the literature is delayed in Grounded Theory research to prevent contamination of the data to be collected and to 'prevent the researcher imposing existing theories or knowledge on the study processes and outcomes' (Birks & Mills 2011, p. 22).

Regardless of the research methodology adopted, a preliminary review of the literature is warranted to justify the need for the study and to determine 'the extent of current knowledge and work undertaken in the field' (Birks & Mills 2011, p. 22). This is especially so for higher degree research work, which aspires to generate new knowledge (Moxham, Dwyer & Read-Searl 2013).

In this research, although familiar with the national and international discourse related to graduate RN practice readiness, the researcher withheld from undertaking a detailed analysis of the literature in the preliminary stages of the inquiry. Instead, a cursory review of the literature was undertaken prior to data collection, for two reasons. Firstly, it was necessary to confirm that the proposed research had not been undertaken and as a result this comprehensive study would make a positive contribution to new nursing knowledge. Secondly, it contributed to the written detailed research proposal for the university to enable confirmation of candidature as a PhD student. Confirmation of candidature was granted based on the review of a detailed research proposal by internal and external academic reviewers and also on an oral presentation by the researcher. The main review of literature was undertaken during, and following, data analysis and is incorporated into the discussion offered in *Chapter Five*. The search strategies used in the preliminary engagement with the literature are now presented.

Visiting the Literature

Information sources, which the researcher engaged with during the preliminary stages of the study included journals, reference books, fact sheets, discussion and position papers. Reports and government and non-government organisation websites published in Australia and overseas were also accessed. Given the decision to transfer nurse education *en masse* in the mid 1980s, from the health sector to the tertiary sector in Australia (Hinton & Chrigwin 2010; Russell 1990; Sellers & Deans 1999), it was necessary to include publications dating back to

1985 and earlier where relevant. This enabled the identification and inclusion of seminal work pertinent to the topic under investigation. The search engines EbscoHost, Google and Google Scholar were accessed and electronic databases including CINAHL, ScienceDirect, ProQuest Central and Scopus were used in the preliminary literature review. Search terms included: nursing education; nursing workforce; transition; practice readiness; work readiness; theory-practice gap; fitness for practice; graduate nurse; newly qualified; recruitment and retention.

Discussion on the aging Australian population and its impact on the nursing workforce, the history of nursing education in Australia, and the current discourse regarding graduate RNs' practice readiness will now ensue. This will enable the reader to more fully situate themselves within the constructs of the study.

Aging Population and the Nursing Workforce

In a discussion paper entitled *Australia's Demographic Challenges* released just over a decade ago, the Australian Government (Treasury 2004, p. 1) revealed that:

The number of Australians aged 65 and over is expected to increase rapidly, from around 2.5 million in 2002 to 6.2 million in 2042. That is, from around 13 per cent of the population to around 25 per cent. For Australians aged 85 and over, the growth is even more rapid, from around 300,000 in 2002 to 1.1 million in 2042. ... At the same time, growth in the number of people of workforce age is expected to fall from around 1.2 per cent per annum over the last decade to almost zero in forty years' time.

Also in 2004, setting to provide principles for workforce planning in health, the *National Health Workforce Strategic Framework* (Australian Health Ministers' Conference 2004, p. 33) raised the need to increase the supply of nurses as a result

of ‘an ageing workforce, ... the expanding role of the nurse and the consequence of the static or declining nurse undergraduate commencements and completions throughout the 1990s’.

The high turnover of nurses and predicted nursing workforce shortage is a globally recognised challenge (ICN 2014; WHO 2006). In 2007, the International Centre for Human Resources in Nursing (ICHRN 2007, p. 1) warned that:

... by 2020 there will be more than one million people aged 60 years and older in the world. This demographic trend has many implications, both for the demand for care and the demand and availability of carers.

In 2015, the Australian Bureau of Statistics (ABS), which is the nation’s official statistical organisation, warned that over the next several decades the aging population is expected to have significant implications for the Australian labour market and health industry (ABS 2015). The demand of an aging Australian population and its impact on the health industry was also highlighted in the recent *2015 Intergenerational Report* released by Australian Government (Treasury 2015a). This report (Treasury 2015a, pp. vii-viii) revealed that ...

Australians will live longer and continue to have one of the longest life expectancies in the world. In 2054-55, life expectancy at birth is projected to be 95.1 years for men and 96.6 years for women, compared with 91.5 and 93.6 years today. ... This has important implications for the demand for health and aged care services A greater proportion of the population will be aged 65 and over. The number of Australians in this age group is projected to more than double by 2054-55 compared with today. There will be fewer people of traditional working age compared with the very young and the elderly. This trend is already visible, with the number of people aged between 15 and 64 for every person aged 65 and over having fallen from 7.3 people in 1974-75 to an estimated 4.5 people today. By 2054-55, this is projected to nearly halve again to 2.7 people.

The projected growth in proportion of Australians aged 65 and over (Treasury 2015b) is illustrated in Figure 1. Naturally, this will have a substantial impact on the health industry in general and on the nursing workforce specifically, with numbers of nurses expected to be in greater demand.

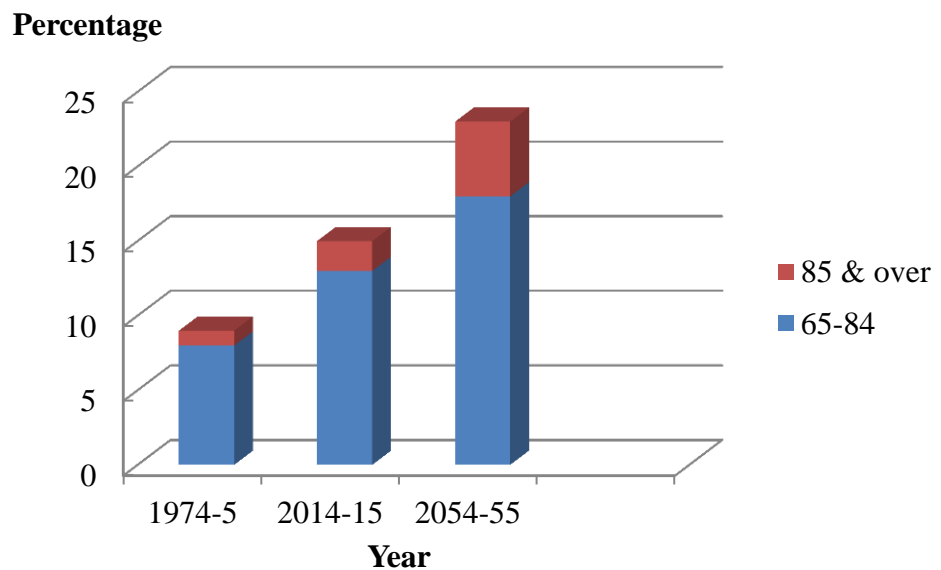


Figure 1: Proportion of Australian population aged 65 years and over (Treasury 2015b)

According to the most recent data available, population trends in Australia and their impact on the nursing workforce are similar to those in most industrial countries (National Health and Hospitals Reform Commission 2009). Similarly, and in addition to the above, the nursing workforce in many First World countries is also aging. This is expected to lead to a large exodus of retired nurses from the workforce at a time when demand for nursing care is on the rise (ICHRN 2007). Warning of the continuing trend of an aging nursing workforce, Health Workforce Australia (HWA 2013, p. 17) remind us that ‘the average age of all nurses

increased by approximately one year, from 43.1 in 2003 to 44.3 in 2009', with 44,823 RNs aged 55 or more in Australia.

This warning was corroborated by the *Nursing and Midwifery Workforce 2013* report conducted by the Australian Institute of Health and Welfare (AIHW 2013b). This report revealed similar trends relating to an aging nursing workforce in Australia putting the proportion of employed nurses and midwives aged fifty years or older at 39.3 percent or on average two in five of all employed nurses and midwives (AIHW 2013b). AIHW (2013a) also reported that in 2012, there were more RNs employed across Australia in the 45-54 year age group than any other age bracket. This is illustrated in Figure 2 below.

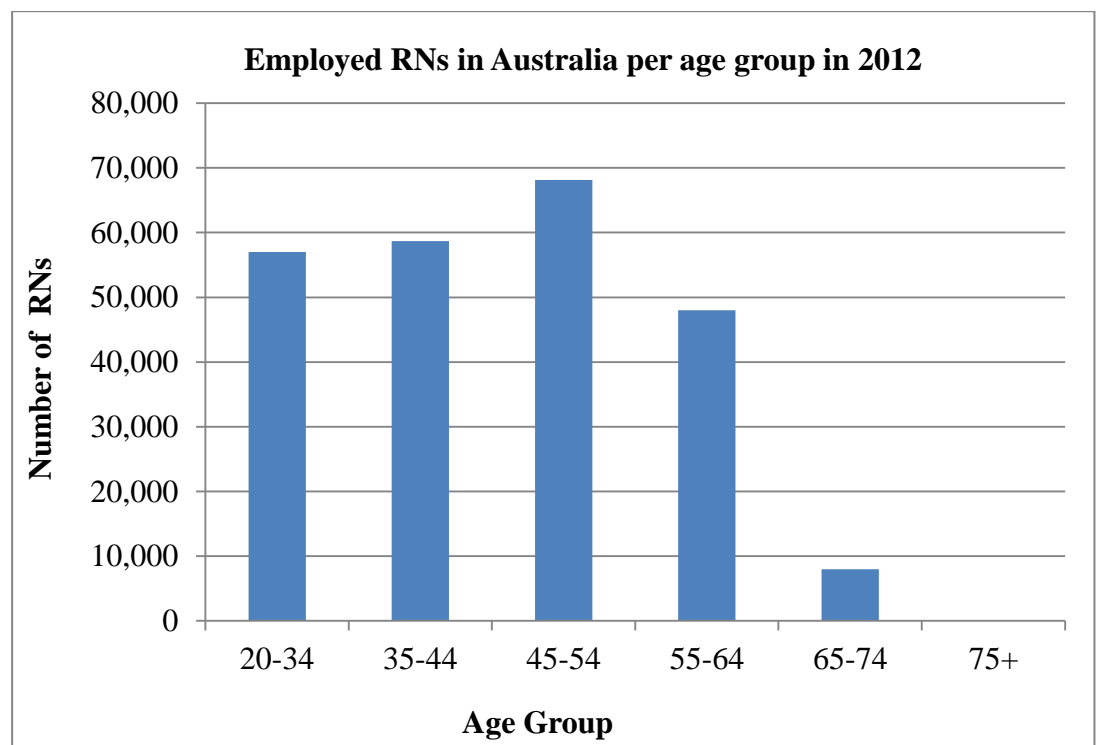


Figure 2: Numbers of employed RNs in Australia per age group in 2012 (AIHW 2013a)

The aging nursing workforce is thought to be a contributing factor to a looming nursing shortage, which threatens the sustainability of the healthcare system and poses a significant challenge to policy makers. This is demonstrated at a state level, with Queensland government figures showing that Queensland faces a looming shortage of RNs estimated to be 9000 by 2020 ‘as the state’s population balloons and large number of nurses retire’ (Miles 2010, p. 21).

The Queensland Nurses’ Union (QNU) disputes this and suggests it to be an under estimate. The QNU claims that it will, in fact, be greater, and describes the State Government’s predictions as conservative. The QNU estimates the shortage of RNs to be closer to 10,000 positions by 2016 and 14,000 positions by 2020 based on the anticipated Queensland Health hospital expansions (Miles 2010; Mohle 2010).

At a national level, Health Workforce Australia (HWA 2012a) in their recent report *Health Workforce 2025 – Doctors, Nurses and Midwives* warn that if current trends continue, Australia will suffer from a shortfall of over 100,000 nurses by 2025. Based on the HWA (2012a) national projections, Figure 3 below reflects the gap between the supply and demand projections for RNs and ENs for 2009-2025 (QNU 2014).

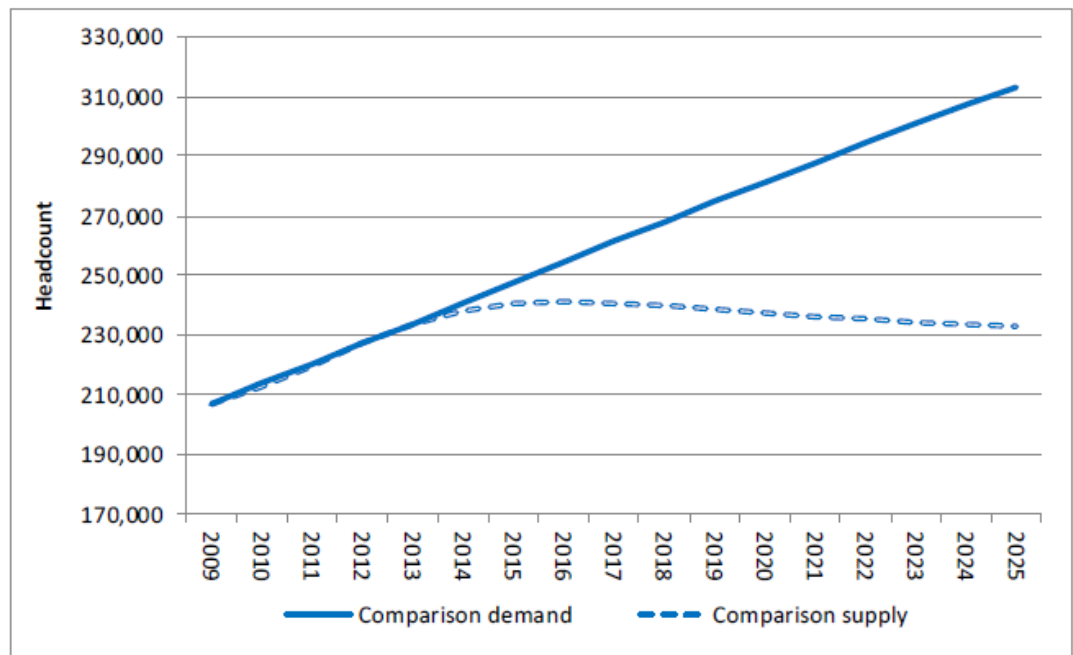


Figure 3: Supply and demand projections for RNs and ENs for 2009-2025 (QNU 2014)

The combined impact of the growing health care demands of an aging Australian population and a forecasted workforce shortage, pose a significant challenge for Australia's health industry and education sectors (HWA 2012a; National Health and Hospitals Reform Commission 2009; PhillipsKPA 2008). In 2008, the then Deputy Prime Minister and Minister of Health Julia Gillard initiated a review of the Australian higher education sector to examine its fitness to meet the future needs of the Australian community and to present recommendations for reform (Bradley et al. 2008). The final report of the *Review of Australian Higher Education*, also known as the *Bradley Report*, set the scene for a substantial expansion in domestic higher education and recommended the Commonwealth Government to fund an overall increase in enrolments in bachelor degrees in Australian universities (Birrell & Edwards 2009).

In response to the *Bradley Report* in 2008 (Bradley et al. 2008) and in recognition of the significance of the anticipated challenges facing the health industry in Australia,

... the Commonwealth and the States committed to an unprecedented reform package of \$1.6 billion investment in the health workforce, comprising \$1.1 billion of Commonwealth funding and \$540 million in State funding. This is aimed at 'meeting the future challenges of the health system through workforce reform by providing \$500 million in additional Commonwealth funding for undergraduate clinical training, including increasing the clinical training subsidy to 30 per cent for all health undergraduate places.

(National Health Workforce Taskforce 2009b, p. 1)

Consequently, in 2009, the Commonwealth Government implemented a demand-driven system by uncapping tertiary entrance enrolments in all public universities and increased funding for programmes (Norton 2013). Such strategy aimed to bridge the gap between supply and demand and therefore, enhance the recruitment and retention of nurses across Australia (HWA 2010). This led to a substantial increase in student enrolments in BN programmes (HWA 2010). According to the Australian Government, Department of Education and Training (2014), a total of 46,629 domestic students enrolled in BN courses and a total of 9,591 persons had completed these courses at the end of 2014. Table 1 provides an overview of the consistently increasing numbers of domestic students enrolling in and completing BN programmes across Australia from 2001 to 2014 (Department of Education and Training 2014).

Table 1: Enrolments and completion count for domestic students in BN programmes across Australia (Department of Education and Training 2014)

Year	Enrolments	Completion
2001	21,949	5,074
2002	22,957	5,269
2003	23,490	5,280
2004	24,257	5,620
2005	25,825	5,628
2006	28,018	6,088
2007	30,267	6,661
2008	31,437	7,170
2009	33,433	7,249
2010	36,206	7,443
2011	38,139	7,903
2012	41,262	8,425
2013	43,878	9,012
2014	46,629	9,591

However, in a media release (CDNM 2012, p. 1) entitled *Training More Nurses and Midwives is not the Panacea to Workforce Shortages*, the then Chair of the Council of Deans of Nursing and Midwifery in Australia and New Zealand, Professor Patrick Crookes explained that:

The Council has repeatedly indicated to Government that unless more is done to stem the haemorrhaging of registered nurses and midwives from the workforce, increasing training numbers will have only limited impact. ... Effort must now be made to support health services to keep nurses and midwives in the system. Too many are leaving because of a lack of adequate support post-graduation. ... There is extensive evidence that shows that nurse retention is high where nurses feel supported in the clinical environment by a nurse educator and when there is good nursing leadership at the clinical level. It's time that governments listened to the evidence and increase support to health services so that they can accommodate greater numbers of less experienced nurses and midwives.

To add complexity to this issue, the increase in funding to educate more RNs at a time when healthcare services were subjected to stringent budget cuts, led to an oversupply of graduates across the country (White 2013). In 2010, and despite the forecasted nursing shortage, the assistant secretary to the Queensland Nurses' Union (QNU) Beth Mohle revealed that, hundreds of graduate RNs were not able to be employed by local health services in Queensland and suggested that all graduate RNs should be employed and properly supported so that they are practice ready and able to respond to future healthcare demands (Miles 2010). Despite the predicted nursing shortage in years to come, the trend of graduate unemployment remained consistent across Australia, where hundreds of graduate RNs were unable to secure employment each year (Macalintal 2013; Murphy 2012).

According to the Australian Nursing and Midwifery Federation (ANMF), which is the national union for nurses and midwives, 'almost every state is affected, with Queensland employing only 10 per cent of graduates, while in Victoria more than 800 are without employment' (Thomas 2012, p. 6). In response to this national trend, Lee Thomas, the federal secretary of the ANMF suggested that 'in light of the predicted shortfall, the health cuts continuing to take place were "near-sighted

and nonsensical” [and] showed scant regard for the long-term health of the community’ (Murphy 2012, p. 12).

In December 2012, the ANMF launched a national campaign ‘*Stop passing the buck, Australia’s nursing grads need jobs*’ aimed at putting pressure on all state, territory and federal governments to secure employments for graduate RNs (Thomas 2012). However, Twigg et al. (2013, p. 2253) summarised the state of affairs and highlighted the challenges encountered by health services in Australia by stating that:

... advancing technology and increased availability of treatment interventions are increasing demand for health care while the downturn in world economics has increased demand for greater efficiency. Nurse managers must balance nurse staffing to optimize care and provide efficiencies.

The temporary oversupply of graduate RNs, the stringent budget cuts across the country and the need to ensure the right staffing levels and skills mix for the provision of quality care in health services has been and remains, the topic for intense and frequent national debate (Macalintal 2013; Mohle 2012; Murphy 2012; Paliadelis 2013; QNU 2014; White 2013).

In response to the projected nursing shortage, Health Workforce Australia (HWA 2013) embarked on consultations with key stakeholders. Such consultations included representatives from regulatory and accreditation bodies, educators and industry across the country. A need to reform training and entry into the workplace were some of the key themes that emerged as a result of these consultations to improve nursing retention and productivity in Australia (HWA 2013).

The above discourse illustrates that a significant number of graduate RNs are currently, and will increasingly be required to join the workforce each year to respond to the growing healthcare demands of an aging Australian population (El Haddad, Moxham & Broadbent 2013). Moreover, the higher rate of job turnover of nurses in acute care hospitals compared to community or rural healthcare settings (Hayes et al. 2006), suggests that the majority of graduate RNs ‘make their initial transition to professional practice within the hospital environment’ (Duchscher 2009, p. 1104). Given that multiple studies have reported that generally, graduates are not perceived to be practice ready, (Duchscher 2009; Evans, Boxer & Sanber 2008; Hickey 2009; Missen et al. 2016; Oermann et al. 2010; Wangenstein, Johansson & Nordstrom 2008; Walker et al. 2013) the insights of BNPCs who lead the education programmes and of NUMs who manage graduates in acute care hospitals, makes a significant contribution to this debate. Their voice and perspective warrants exploration.

History of Nursing Education

Australian nurses ‘trained’ in hospitals in apprenticeship style programmes until the mid-1980s (McGrath et al. 2006; Russell 1990). In this model of nurse training, the educational needs of students were superseded by the needs of the training hospital (Brennan & Timmins 2012; Sellers & Deans 1999) where trainee nurses were expected to provide a high proportion of hospital service needs (Russell 1990). While this style of training produced very skilled nursing graduates, concerns regarding their theoretical knowledge began to grow in the 1960s and 1970s, leading to increased lobbying by peak nursing bodies for the

transfer of nursing education to the tertiary sector (Fetherstonhaugh, Nay & Heather 2008).

Nurse training, as it had long been known and accepted in the 1960s and 1970s, was about to change when nurse education within some jurisdictions started to move to the higher education sector. The first university programme to be offered to nurses in Australia was in 1967 at the University of New England, in New South Wales (Williams et al. 2000). After decades of lobbying by educationalists and nursing peak bodies across Australia, the Commonwealth Government finally authorised the transfer of nurse education *en masse* from the health sector to the tertiary sector on 24 August 1984 (Hinton & Chrigwin 2010; Russell 1990; Sellers & Deans 1999; Williams et al. 2000). Consequently, the last intake of nurses into the hospital-based training system in Australia was in 1990 (Crisp & Taylor 2005; Moxham 2015). Although Australian nurse leaders campaigned for a four-year degree programme, the federal government then only agreed to fund a three-year Bachelor of Nursing programme (Kenny et al. 2004; Williams et al. 2000), ‘particularly given the implications for fiscal policy’ (Reid 1994, p. 178). Such transfer of nursing education to the tertiary sector was believed to instigate improvements in the theoretical knowledge and understanding of graduates (Fetherstonhaugh, Nay & Heather 2008).

In a seminal national review of nursing education titled, *‘Nursing education in Australian universities: report of the national review of nurse education in the higher education sector - 1994 and beyond’*, Reid (1994) endorsed the transfer of nursing education to the tertiary sector. This review highlighted the significance of placing nursing on an equal professional footing with other health disciplines,

like physiotherapy, occupational therapy and social work, confirming the importance of tertiary education for the recognition of nursing as a profession. A national survey undertaken a decade after the transfer of nursing education to the tertiary sector, revealed that most Australian academics believed that nurse preparation would not revert back to hospital-based training in Australia (Sellers & Deans 1999). According to Sellers and Deans (1999), Australian academics involved in the survey also believed that workforce requirements rather than disciplinary development and academic standards would be the drivers of nursing curricula. As such, research into curriculum design, clinical practice, clinical competence etc. and this study, which examines the perspective of NUMs and BNPCs regarding newly graduate RN practice readiness, enables greater understanding of the issues related to the nursing workforce.

Following the change in undergraduate nurse education, a ministerial taskforce was commissioned by Queensland Health (QH) in 1998 to investigate nursing recruitment and retention issues as a response to the predicted nursing shortage. More than a decade ago, QH recommended a review of nursing education to match industry needs (QH 1999). Despite this recommendation it was not until April 2001, that the Victorian Centre for Nursing Practice Research (VCNPR) was commissioned by the Commonwealth Department of Education, Training and Youth Affairs (DETYA) and the Commonwealth Department of Health and Aged Care to undertake a national review of nursing education and identify recent and predicted changes in health care services. It also reviewed the types of skill and knowledge that the nurse is thought to require so as to best manage these predicted changes (Commonwealth of Australia 2001).

This review led to the seminal report, namely the *National Review of Nursing Education 2002: Our Duty of Care Report*, which determined that the provision of nursing care had become highly specialised and technologically demanding in response to changes in healthcare services (Heath et al. 2002). This review also highlighted the fact that contemporary RNs require broad based clinical knowledge and skills; the ability to provide personalised care while working with a fast developing wide range of technology; the ability to critically consume and partake in relevant research and the ability to be self-directed and involved in ongoing learning in order to cope with the ever changing, technologically diverse health care provision (Heath et al. 2002). Moreover, this seminal national inquiry revealed that the complexity of today's nursing practice in addition to the current and predicted nursing shortage place graduate RNs in a difficult and precarious position (Heath et al. 2002).

The decision to transfer nursing education to the tertiary sector was reaffirmed by the findings of the *National Review of Nursing Education 2002: Our Duty of Care Report* (Heath et al. 2002) and further re-enforced in 2006 by the Health Ministers in the *National Nursing and Education Taskforce Final Report* (Australian Nursing and Midwifery Council [ANMC] 2008). According to the ANMC (2009, p. 25), 'the establishment of the bachelor degree as the minimum qualification for RNs brings national consistency to nursing education in Australia'.

The transfer of nursing education to the tertiary sector in Australia is consistent with international efforts to enhance the education level and quality for RNs (ANMC 2009). Several international studies, reports and position statements (American Association of Colleges of Nursing 2000; Canadian Nurses

Association & Canadian Association of Schools of Nursing 2004; Cowan, Norman & Coopamah 2007; Lofmark, Smide & Wikblad 2006; United Kingdom Central Council 1986) acknowledge that higher levels of education such as BN programmes are regarded positively and are expected to deliver better nursing performance and improved levels of critical thinking and decision making (Heath et al. 2002).

Reviewing nursing education was, and is, a global phenomenon. Changes in nursing education in the United States of America (USA) were also scrutinised over the years. The first baccalaureate nursing programme was offered at the University of Minnesota in 1909 (Scheckel n.d.). Even though the development of baccalaureate nursing education continued in the USA, diploma programmes prevailed (Scheckel n.d.). In a seminal North American report titled *Nursing for the Future*, and later referred to as *The Brown Report*, Esther Brown, a North American civil rights advocate recommended in 1948 that schools of nursing are best placed in universities and colleges in the USA (University of Rochester 2011). *The Brown Report* also recommended that the financial burden for the running of these schools be partly assumed by the public (University of Rochester 2011).

Almost two decades later in 1965, the American Nurses' Association (ANA 1965) released its first position paper on education for nurses in the USA. In this paper, the ANA (1965, p. 5-6) strongly argued that:

The education for all those who are licensed to practice nursing should take place in institutions of higher education. ... [The] minimum preparation for beginning professional nursing practice at the present time should be baccalaureate degree education in nursing.

The ANA position in 1965 and similar future positions regarding nursing education in the USA were met with fierce opposition from educators and employers alike. It was not until 1996 that the American Association of Colleges of Nursing board (2000) approved the baccalaureate degree in nursing as the minimal educational preparation for professional nursing practice in the USA.

In Canada the first formal nurse training programme based on the hospital apprenticeship model was established in 1874 in Ontario. This led to a proliferation of nursing schools in major hospitals across the country (Canadian Museum of History n.d.). Since then, Canadian nurse leaders lobbied hard for establishing professional organisations, licencing legislation and university education for nurses, which led to the establishment of the first baccalaureate degree programme in nursing in 1919 (Canadian Association of Schools of Nursing 2014). A baccalaureate degree in nursing became the entry requirement for the profession in 1982 to ensure that nurses have the necessary knowledge and skills required for the 21st century healthcare system (Canadian Nurses Association & Canadian Association of Schools of Nursing 2004). This goal was achieved in 2005 in British Columbia and the majority of provinces in Canada, where all entry-level nursing programmes moved to the baccalaureate level (Wolff, Pesut & Regan 2010).

In the United Kingdom (UK), 98 percent of nurse education took place within schools of nursing rather than higher education institutions up until 1989 (Meerabeau 2001). As a consequence of the *Judge Report* (Royal College of Nursing 1985), the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC 1986) embarked on a comprehensive review of

educational preparation of nurses in 1986. At a time when educational compromises were made to ensure wards were well staffed, this review resulted in strong recommendations to transfer nursing education to the tertiary sector with an emphasis on reducing clinical time and keeping nursing students supernumerary to staffing establishments throughout the whole period of preparation (UKCC 1986). According to Fulbrook et al. (2000, p. 351),

The drive for this was to ensure that future student nurses would not be viewed as apprentices but supported by appropriate clinical supervision, which was to coincide with classroom-based learning. Their introduction to the practice areas would also be staggered and placements would be shorter.

Furthermore, it was anticipated that these changes would allow academics to liaise with their counterparts in other education sectors and aid in achieving higher standards of education (UKCC 1986). The UK government supported the recommendations of this review and as a result ‘a radical new and costly change in nursing education programmes, *Project 2000* was launched in 1989 with increased theory and a change to supernumerary status of students’ (Deans, Cogdon & Sellers 2003, p. 146). With the implementation of *Project 2000* curriculum, the practice lead approach to nurse education was replaced with a theory lead one by removing clinical skill acquisition from schools of nursing and positioning it in practice placement areas (Borneuf & Haigh 2010).

Although, the transfer of nursing education to the tertiary sector in the UK was marked with controversy (Meerabeau 2001), Watson, R (2006, p. 626) argued in favour of this education reform because ‘nurses are required to act beyond the level of mere competence, ... to be capable of adapting to unfamiliar circumstances in unfamiliar contexts’. This assertion was affirmed by Cowan,

Norman and Coopamah (2007) who stated that the preparation of nursing students in the UK in higher education institutions rather than apprenticeship style programmes within hospitals, instigated improvements in nurses' analytical thinking and adoption of evidence-based practice.

Looking closer to Australia, in New Zealand, nurses were also employed in apprentice style training in hospitals until the early 1970s (Adlam, Dotchin & Hayward 2009). However, 'following the *Carpenter Report* in 1971 the responsibility for nurse education was gradually transferred from the health sector's Hospital Schools of Nursing, to the Department of Education' (Andersen 2008, p. 3). Nursing diploma programmes were introduced in 1973 in New Zealand with the aim of preparing 'nurses who could deliver an improved standard of patient care within the changing health service' (Horsburgh 1989, p. 610). In response to overseas trends in nursing education, a commitment was finally made in the late 1980s by the nursing profession to offer degree programmes in New Zealand, which became a reality in 1993 (Andersen 2008).

Table 2, provides a comparison of the year in which higher education became the standard for professional nursing education in nine countries. It is worthy to note that differences occur in the length of programmes in many countries as a result of qualifications upon entry. This is contributing to the worldwide differences in the educational preparation of registered nurses.

Table 2: The year higher education became the standard for professional nursing education in nine countries

YEAR	COUNTRY
1982	Canada
1984	Australia
1989	United Kingdom
1993	New Zealand
1995	Scotland
1996	United States of America
2002	Republic of Ireland
2004	Germany
2009	France

Strengthening nursing education was indeed the focus of Ministers of Health of member states in the European region of the World Health Organization (WHO) in the year 2000. These Ministers of Health released *The Munich Declaration* urging all relevant authorities to take action ‘to strengthen nursing and midwifery by improving initial education and access to higher education’ (WHO 2000, p. 1). To support the implementation of *The Munich Declaration*, standards for nursing and midwifery for members of the European Union (EU) were developed (WHO 2009, p. 4) stipulating that:-

The training of nurses responsible for general care shall comprise at least three years of study or 4600 hours of theoretical and clinical training, the duration of the theoretical training representing at least one-third and the duration of the clinical training at least one half of the minimum duration of the training. Member States may grant partial exemptions to persons who have received part of their training on courses which are of at least an equivalent level.

Based on these standards, it was determined that the duration of the clinical hours of training for nurses in EU countries, should consist of at least 2300 hours (Lahtinen, Leino-Kilpi & Salminen 2014; Mallaber & Turner 2006).

In Australia, a total of 44 education programmes of study are currently approved by the NMBA that lead to registration as a registered nurse (HWA 2014). While the majority of these programmes are Bachelor of Nursing (BN), two Bachelor Graduate Entry and four Master programmes also lead to registration as a registered nurse in Australia as illustrated in Figure 4. In this thesis, all three types of programmes leading to registration as a registered nurse will be referred to as BN programmes.

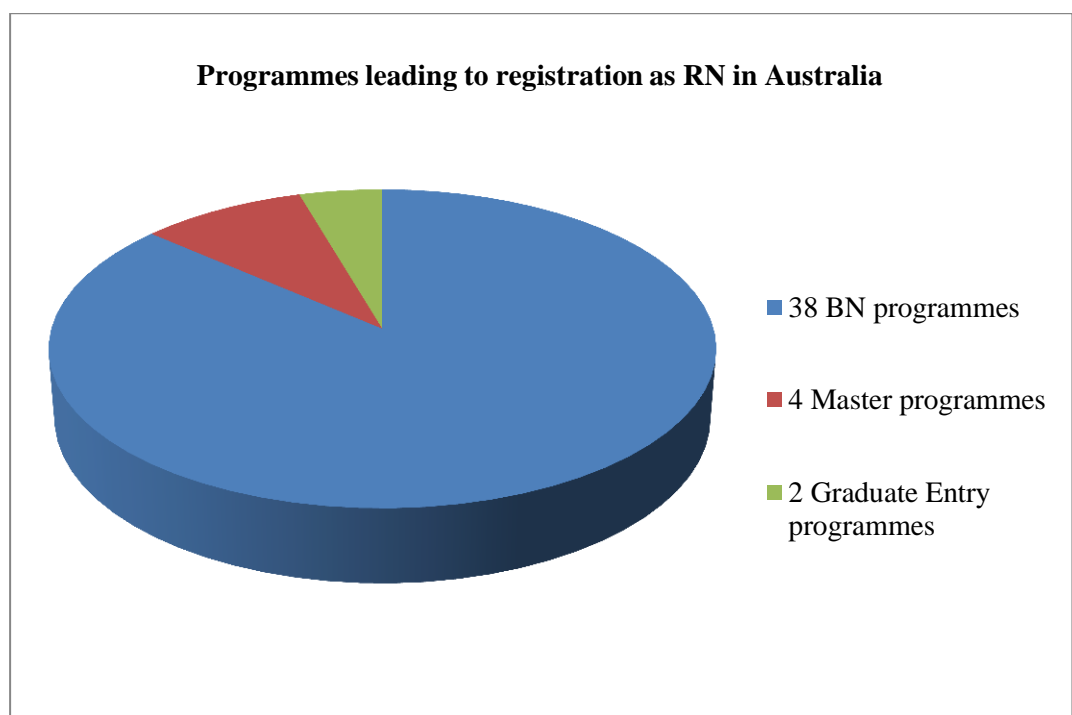


Figure 4: Range of nursing programmes in Australia leading to registration as RN (HWA 2014)

So far, Australian universities have had to formulate their BN curricula based on the *National Competency Standards for the Registered Nurse* (NMBA 2006). These are recognised as the minimum professional standards for the role of the RN in the Australian context (ANMAC 2012). These standards were recently reviewed and replaced by the *Registered Nurse Standards for Practice* in February 2016, which are due to take effect on 1st June 2016 (NMBA 2016). Students undertaking BN programmes are required to complete a minimum of 800 hours of clinical training (ANMAC 2012). According to HWA (2014), clinical training hours in Australian nursing programmes range between 800 and 1478 hours, with an overall average of 899 hours which comprise 40-45 percent of the course time. The most currently available data regarding the number of nursing programmes leading to registration in Australia and their required off-campus clinical training hours in comparison to the national minimum of 800 hours (HWA 2014, p. 9) are represented in Figure 5.

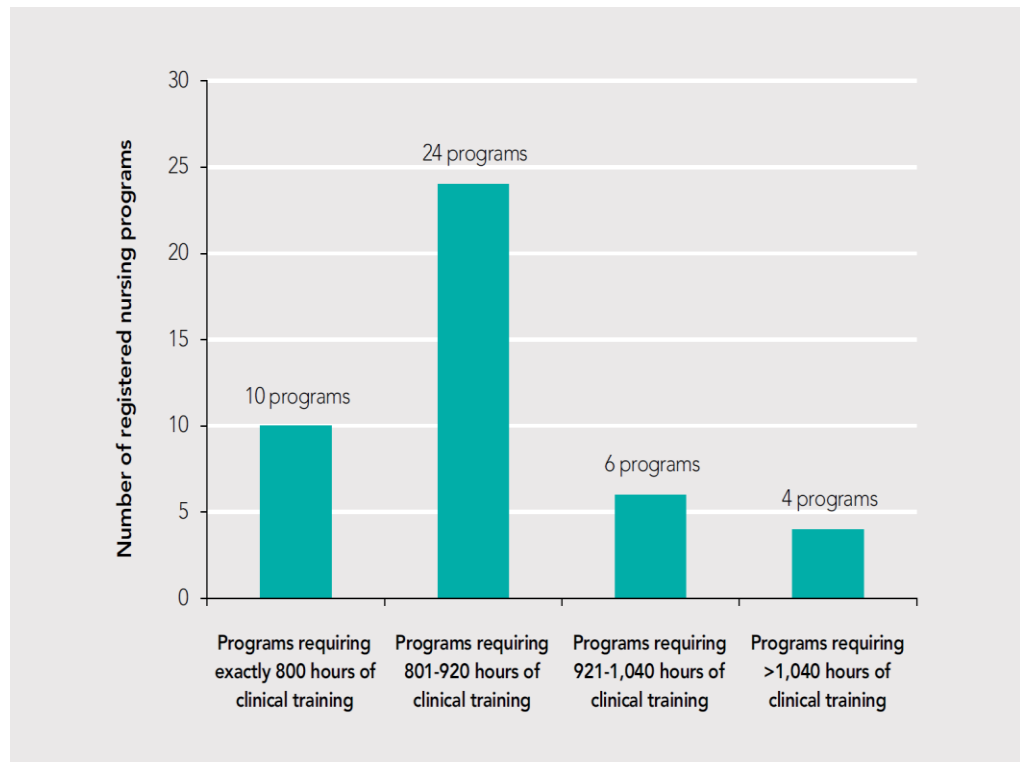


Figure 5: Number of nursing programmes and their required off-campus clinical training hours in Australia (HWA 2014)

With registration, the graduate RN is declared to be practice ready as a safe and competent practitioner, but notably at novice level (McGrath et al. 2006). Furthermore, in a 2008 position statement regarding the role of the RN in Australia, the Australian Nursing and Midwifery Council (ANMC 2008) considers the role of the RN to be a professional function; one that encompasses a broad range of clinical expertise such as the ability to think critically about patient care, to accurately assess patients and safely carry out evidence-based nursing interventions.

In April 2010 and under *Section 43* of the *Health Practitioner Regulation National Law 2009 Act*, the Australian Nursing and Midwifery Accreditation Council (ANMAC) was established by the Nursing and Midwifery Board of

Australia (NMBA) as the single independent accreditation authority for the nursing and midwifery professions in Australia (ANMAC 2014). ANMAC ‘plays an important role in protecting the health and safety of the Australian community by promoting high standards of nursing and midwifery education’ (Adrian 2013, p. 75). Adrian (2013, p. 75) notes that ‘quality education assures the community that nurses and midwives who complete accredited programs can become registered, practice and care for people in a safe and competent manner’. Furthermore, undertaking a BN degree in Australia provides opportunities to develop knowledge and skills in the area of nursing that can be applied in varying clinical contexts (Moxham 2015).

Practice Readiness

Prior to transferring nurse education to the tertiary sector in Australia, student nurses were recruited directly by hospitals where they undertook their training and usually resided in nurse’s quarters on the hospital campus (Fetherstonhaugh, Nay & Heather 2008; Mannix, Wilkes & Luck 2009). According to Mannix, Wilkes and Luck (2009, p. 60), these student nurses ‘grew to know the ways and the idiosyncrasies of their training hospitals ... and were accepted as being an integral part of hospital life and central to the nursing workforce’. The apprenticeship hospital based training enabled students to gain extensive practical experience in familiar hospital settings (Brennan & Timmins 2012; Fetherstonhaugh, Nay & Heather 2008).

Given the length of time that nurse education has been in the higher education sector, it is surprising that the debate about university education versus hospital based training continues to linger (El Haddad, Moxham & Broadbent 2013). Jackson and Daly note that the response to the Australian ‘electioneering promises to introduce a return to hospital schools of nursing’ in 2007, was rather contentious (2008, p. 1) and explain that while some people are ...

... hankering for the nurses of old, many nurses are hankering for the public health system of old – a health system that while having its flaws, provided longer average length of stay, more manageable patient acuity and casemix patterns, more adequate resources and greater opportunities to learn-on-the-job. This meant that nurses were better placed to be able to provide the sort of care that patients expect to receive, and nurses want to supply. While there may be debate about the causes of the current crisis in the health system, it can’t be laid at the door of nurses education.

(Jackson & Daly 2008, p. 2)

Similarly in the United Kingdom and in response to a debate calling for a return to the ‘good old days’ of nurse training, McKenna et al. (2006, p. 135) remind us that ...

It is conveniently forgotten that nurses in the ‘good old days’ were often regarded as handmaidens – subservient, dependent and unthinking, and patients were subjected to ritualistic and routine practices passed down without question from one generation of nurses to the next.

As with questions being raised today about the work readiness of BN graduates, over three decades ago, Sax (1978) reported that the theory-practice gap and the inadequate preparation of nurses were perceived as limitations associated with hospital-based training programmes in Australia. Likewise, Fulbrook et al. (2000, p. 351) suggest that nursing students in apprenticeship programmes in the UK were commonly used ‘as an extra pair of hands’, thus making their clinical

development secondary to the priorities of the health service. Not surprisingly, these graduate nurses ‘felt ill equipped to cope with the demands of an evolving health care system’ (Fulbrook et al. 2000, p. 351).

The notion of a supposed theory-practice gap is therefore, not new (Monaghan 2015). It represents the difference between the theoretical knowledge of what should happen and the reality of actual performance (Clark & Holmes 2007). However, it is significant to note that the current discourse regarding the supposed theory-practice gap emanates from the perspective that students have more theory than practice. Whereas, the notion of theory-practice gap that was purported to be a problem in the apprenticeship style training programmes in the 60s and 70s both in Australia (Fetherstonhaugh, Nay & Heather 2008; Sax 1978) and the UK (Fulbrook et al. 2000), emanates from the perspective that students had more practice than theory.

The theory-practice gap and the subsequent perceived limitations of graduate RNs continue to be prominent in nursing discourse despite the movement of nursing education to the tertiary sector (Berkow et al. 2009; Candela & Bowles 2008; Clark & Holmes 2007; Cubit & Ryan 2011; Evans, Boxer & Sanber 2008; Goh & Watt 2003; Marks-Maran et al. 2013; Monaghan 2015). The ‘view that academics are distanced from nursing practice and its values and norms’ reinforces the perception of the theory-practice gap (Tuohy 2011, p. 27).

Just over a decade following the transfer of nursing education to the tertiary sector in Australia, a State-wide survey was conducted in early 1997 in New South Wales (NSW) to explore the expectations of newly graduated RNs in the

workforce (Madjar et al. 1997). This study, which involved 493 new graduate RNs and 729 experienced RNs who came in contact with them, revealed that:

Beginning registered nurses feel anxious and uncertain on entry to practice and recognise that they will require guidance and assistance from more experienced nurses. A significant number feel unsure as to whether they will be accepted by their more experienced colleagues and whether they will be able to satisfy other nurses and other members of the health team with their performance.

(Madjar et al. 1997, p. ix)

Despite the implementation of transition support programmes, also known as residency programmes, since the transfer of nurse education to the tertiary sector, new graduate nurses continue to report suboptimal transition experiences (Clare et al. 1996; Evans, Boxer & Sanber 2008; Newton & McKenna 2007; Mooney 2007; Morrow 2009; Rush et al. 2014; Wu et al. 2012). In a qualitative Australian study conducted in seven hospitals in NSW, Evans, Boxer and Sanber (2008) aimed to determine the strengths and weaknesses of transition support programmes for new graduate nurses. Nine new graduate RNs and thirteen experienced RNs participated in this study. Findings revealed that graduate and experienced RN participants expressed dissatisfaction with the level of preparation of nursing students and their ability to function as RNs upon graduation (Evans, Boxer & Sanber 2008). The perception of an inadequately prepared nursing workforce was also echoed by nurses in Queensland in the 2007 and 2010 surveys conducted by Hegney, Eley and Francis (2013). Moreover, ‘this so-called theory-practice gap appears to be a global phenomenon and has been repeatedly debated within nursing’ (Maben, Latter & Clark 2006, p. 466).

The transition period of graduate RNs is ‘acknowledged as a time of significant stress as graduates endeavour to consolidate their nursing knowledge and gain mastery of clinical skills in a working environment’ (Goh & Watt 2003, p. 14). This is the period when graduate RNs experience role conflict and adjustment (Kilstoff & Rochester 2004), bullying and incivility (Laschinger et al. 2010, 2016; Rush et al. 2014) and a sense of being unprepared to face the responsibilities of being an RN (Newton & McKenna 2007). This is portrayed in Kramer’s (1974) seminal work as a time of ‘*reality shock*’. Over twenty years later, graduate RNs’ role conflict was referred to as a process of ‘*moral distress*’ by Kelly (1998). More recently, Duchscher (2009, p. 1111) termed this phenomenon as ‘*transition shock*’, and explained that newly graduated RNs usually ...

... experience role performance stress, moral distress, discouragement and disillusionment during the initial months of their introduction to professional nursing practice in acute care’. ... Transition shock represents the initial reaction by new nurses to the experience of moving from the protected environment of academia to the unfamiliar and expectant context of professional practice.

Moreover, it is the period when graduate RNs encounter practice realities that challenge the values and ideals they were taught and would have embraced as students (De Bellis et al. 2001; Duchscher & Cowin 2006; Horsburgh 1989; Kelly 1998; Kilstoff & Rochester 2004; Kramer 1974). It is also the time when they grapple with new bureaucratic and organisational work structures (Maben, Latter & Clark 2006), with hospital processes and procedures and gain an understanding about their place in the clinical setting (Newton & McKenna 2007).

A North American study, which utilised qualitative and quantitative approaches, invited 200 preceptors to identify their views of new graduates’ readiness for

practice. This study highlighted that the clinical exposure offered during the academic programme does not adequately prepare the graduate for practice (Hickey 2009). Hickey (2009, p. 39) recommended that ‘students should experience more of the reality of nursing during their academic preparation’.

This discourse is not new and it illustrates that new graduates do not easily transition into the role of an RN having to come to terms with not only clinical issues and time management but also assimilating with their professional identity. Over three decades ago, Hall (1980, p. 158) cautioned against having unrealistic expectations of graduate RNs and suggested that ‘the nurse is the only professional who is expected to be a completely finished product when she successfully completes basic training’. Highlighting the unrealistic expectations of graduates, Horsburgh (1989) noted that newly graduated RNs are expected to supervise enrolled nurses and students. Clare et al. (1996, p. 170) warned that few practice-based professions ‘expect their new graduates to accept responsibility for life and death decisions.

This issue was raised recently by the then Chief Executive Officer of the *Australia College of Nursing* (ACN), which is a key national professional nursing organisation. Debra Thoms proclaimed that it is important for many reasons, including the retention of RNs, that new graduates are supported during this difficult phase (Thoms 2014).

By and large, and since the transfer of nursing education to the tertiary sector, healthcare organisations have recognised that transition programmes, also known as residency programmes in North America, are fundamental for providing

support to graduate RNs during their first year of practice (Adamack & Rush 2014; Adlam, Dotchin & Hayward 2009; Casey et al. 2004; Cubit & Ryan 2011; Dyess & Parker 2012; El Haddad 2014; Johnstone, Kanitsaki & Currie 2008; Missen, McKenna & Beauchamp 2016; Park & Jones 2010; Rhodes et al. 2013; Rush et al. 2013; Spector et al. 2015). These programmes are considered essential to bridge the alleged theory-practice gap (Adamack & Rush 2014; Benner 2012; Cubit & Ryan 2011; Levett-Jones & FitzGerald 2005; Rhodes et al. 2013) and 'to redress the perceived inadequacy of university preparation for registered nurses' (Evans, Boxer & Sanber 2008, p. 20). In Australia, graduate nurse transition programmes are usually one-year programmes offered by both the public and private health sectors to provide structured support for new graduate RNs (McKenna & Newton 2008). Despite the lack of consistency and the variation in programme length, rotations, funding and structure, transition programmes appear to have strong merits and a positive impact on the retention of graduate RNs (Adamack & Rush 2014; Adlam, Dotchin & Hayward 2009; Anderson, Hair & Todero 2012; Edwards et al. 2011; Missen, McKenna & Beauchamp 2014; Rush et al. 2015). In New Zealand, participation in structured one-year transition programmes in acute hospitals is thought to have led to improvements in retention of newly graduated nurses (North, Leung & Lee 2014).

To further enhance the transition experiences and retention rates of newly graduated nurses, Evans, Boxer and Sanber (2008) recommend that education institutions need to improve clinical exposure of student nurses to real work situations in order to gain a genuine understanding of the role of the RN. Mannix, Wilkes and Luck (2009), concur with the above recommendation and maintain

that education institutions, health professionals and regulatory bodies all play a major role in preparing graduate RNs by optimising the clinical learning opportunities student nurses are exposed to while on clinical placement.

Clinical learning opportunities are said to be difficult to obtain (Watson, M 2006). Education providers across Australia have expressed their concerns to nursing regulators regarding the escalating difficulties in accessing appropriate clinical placements for their nursing students (CDNM 2005; HWA 2012b). Furthermore, the limited availability of appropriate clinical placements in response to the substantial increase in nursing student enrolments has been identified as a major concern hindering further growth in the nursing and midwifery workforce in Australia (CDNM 2012; HWA 2012b; National Health Workforce Taskforce 2009a; PhillipsKPA 2008; Productivity Commission 2005; Watson, M 2006). This was echoed by the National Health Workforce Taskforce (2008), which estimated that by the 2013 academic year, the growth in demand for nursing clinical placements would have grown by more than 613,750 placement days per annum.

The International Council of Nurses (ICN 2009, p. 6) also contends that the perception of employers generally, is that today's graduate RNs are not 'prepared for the realities of practice nor do they have the competencies needed by current health care services'. Moreover, the ICN (2009) considers education institutions and healthcare organisations as significant stakeholders and warns that the persistent lack of appropriate clinical role models, overcrowded clinical placement areas and ineffective clinical teaching models, continue to impact on the graduate RNs' practice readiness.

Recent papers from the United States of America also report that graduate RNs are supposedly not adequately prepared for the challenges of clinical practice, from the perspective of nurse managers (Oermann et al. 2010). Nor are they apparently adequately prepared from the perspective of graduate RNs themselves (Cheeks & Dunn 2010).

In a discussion paper entitled *Why Can't New Registered Nurse Graduates Think Like Nurses?*, Del Bueno (2005) reviewed the aggregate results for competency assessment of graduate RNs from 1995 to 2004 in the United States using the Performance Based Development System. Del Bueno (2005, p. 280) argues that graduate RNs, even though 'bright enough to meet academic entry and ... pass state licensing requirements', lacked critical thinking and were not equipped with safe clinical judgment ability. Del Bueno (2005, p. 281) also suggested that:

A highly probable cause is the emphasis on teaching more and more content in the nursing education curricula rather than a focus on use of or application of knowledge. ... Students need consistent experience with both visual simulations and real patients to learn how to effectively focus on and manage patient problems. ... Smart nurses are effective nurses when they think critically, not when they can pass multiple-choice tests.

More recently in the USA, two large studies determined that structured transition programmes are necessary to improve outcomes for graduate RNs transitioning to practice (Berkow et al. 2009; Spector et al. 2015).

Further to this, recent studies in Canada also reported on the perceived lack of practice readiness of graduate RNs as they entered the workplace (Romyn et al. 2009; Wolff, Pesut & Regan 2010). Romyn et al. (2009) acknowledged that the perceived lack of practice readiness of graduate RNs as they enter the workforce is of concern to all stakeholders including educators and employers in Canada.

They undertook a qualitative study involving focus groups with 186 graduates, staff nurses, employers and educators to gain an understanding of the process of making the transition from student to graduate nurse (Romyn et al. 2009). In this Canadian study ‘participants suggested that the term *hit the floor running* reflects the urgent needs of practice settings and exemplifies unrealistic expectations of new graduates’ (Romyn et al. 2009, p. 8). Romyn et al. (2009, p. 7) add that ...

The idea that breadth, rather than depth of knowledge is privileged in nursing curricula was shared by many. Questions emerged regarding “generalist” educational preparation and whether it is possible for students to acquire the knowledge and skills required to function effectively in all practice settings, including rural and specialty areas where the demands and expectations of new graduates are “enormous.” Attaining “complete practice readiness” before entering the workforce was deemed impossible.

Wolff, Pesut and Regan (2010) conducted an exploratory study in Canada involving 150 nurse participants from the practice, education and regulatory sectors. The study revealed that ‘participants’ expectations and understandings of new graduate practice readiness were influenced by the historical and social context within which nursing education and professional practice is grounded’ (Wolff, Pesut & Regan 2010, p. 187). These authors argue that ‘with the movement away from the shared accountabilities between the education and practice sectors, it is no longer clear who plays what role in ensuring that nurses are practice ready’ (Wolff, Pesut & Regan 2010, p. 190).

The significance of enhancing the transition experiences of graduate RNs cannot be over emphasised to enable the sustainability of the nursing workforce (Berkow et al. 2009; North, Leung & Lee 2014; Spector et al. 2015). This is so, given the growing complexity of a resource-constrained healthcare system; fast changes in

healthcare technologies; increasing healthcare demands of an aging population; and the looming nursing shortage (Spector et al. 2015).

Several studies reveal that the retention of graduate RNs is often linked to their first year experience (Casey et al. 2004; Cowin & Hengstberger-Sims 2006; Cubit & Ryan 2011; Halfer & Graf 2006; Johnson & Preston 2001; Kelly & Ahern 2008). Nurse recruitment and retention is a constant battle for the global healthcare industry (Tillott, Walsh & Moxham 2013) with Halfer and Graf (2006) suggesting that attrition from nursing is a direct result of job (dis)satisfaction. Other contributors to the attrition of graduate RNs are inadequate training (Marcum & West 2004), inadequate socialisation processes (Kelly & Ahern 2008) and inadequate support while experiencing the different phases of what is classically referred to as *Reality Shock* (Casey et al. 2004; Cowin & Hengstberger-Sims 2006; Cubit & Ryan 2011; Johnson & Preston 2001; Kramer 1974).

Despite the conjecture that new graduate RNs are not practice ready as a result of their educational preparation, Cowin and Jacobsson (2003) cautioned against blaming new graduates' high attrition on the education system for their purported lack of work-ready preparation. They suggested that retention strategies should focus mainly on workplace reforms (Cowin & Jacobsson 2003). These authors also suggest that graduate RNs require formal support programmes provided by nurses who have had enhanced preceptorship training and who are appropriately compensated for their role (Cowin & Jacobsson 2003). Strategies therefore, to boost graduate RNs' confidence and support their transition from student nurse to RN are required so as to enhance their job satisfaction and therefore reduce

attrition rates (Chang & Hancock 2003; Cowin & Jacobsson 2003; Gavlak 2007; Thoms 2014).

Not only are there professional consequences, but high attrition rates of graduate RNs have significant financial implications for healthcare services. In North America, Halfer and Graf (2006) claim that the cost to employers for replacing a nurse with less than one year of tenure is US\$40,000 (AU\$52,631). This cost has risen to more than USD \$82,000 (AUD \$107,894) in 2007 in the United States (Jones 2008) or to 'somewhere between 75% and 125% of a nurses' salary' (Anderson, Hair & Toderro 2012, p. 206). Beecroft, Dorey and Wenten (2007, p. 41) add that high attrition rates of graduate nurses 'affect hospital efficiency because of the costs associated with recruitment and orienting replacement nurses, hiring temporary agency nurses and supervising new nurses'.

In Australia, taking into account costs such as loss of productivity, advertising, interviews and orientation, it is estimated that the cost of replacing a graduate RN with a base salary of AUD \$48,000 is AUD \$100,000 (USD \$76,227) (Cubit & Ryan 2011). Given the current forecast of nursing shortage (HWA 2012a) and the need for fiscal responsibility (Twigg et al. 2013; Zinsmeister & Schafer 2009), it seems imperative for healthcare services to develop effective transition support programmes that can contribute to enhancing the retention of graduate RNs (El Haddad 2014). Despite the suggestion that effective transition support programmes enhance the retention of graduate RNs (Chang & Hancock 2003; Cubit & Ryan 2011; Halfer & Graf 2006; Kelly & Ahern 2008; Marcum & West 2004; Missen, McKenna & Beauchamp 2014), Levett-Jones and FitzGerald

(2005) warn that there is still a lack of understanding of the graduate RNs' needs and requirements within the Australian context.

The discourse above suggests that despite implementing various reforms in undergraduate (pre-registration) nurse education (Gerrish 2000; Usher et al. 2015), graduate RNs' transition to professional practice remains challenging and stressful (Adamack & Rush 2014; Berkow et al. 2009; Duchscher 2009; Halfer & Graf 2006; Hegney, Eley & Francis 2013; Hickey 2009; Hinton & Chirgwin 2010; Spector et al. 2015). Several studies highlight the significant role NUMs play in providing support for newly graduated RN during the transition period (Dyess & Parker 2012; Williams et al. 2014). Dyess and Parker (2012, p. 622) suggest that 'nurse managers are in an ideal position to determine, develop and provide strategies to support the transition phase of new nurses entering the workforce and profession'. Moreover, Duchscher (2009) asserts that preparing senior nursing students with knowledge to help them integrate into the workforce is necessary to limit the transition shock.

The above discussion reflects the longstanding national and international debate, which contributes to the conjecture that newly graduated RNs are unprepared for the challenges of the current healthcare system and therefore not ready for practice. The significance of this study is that it offers an understanding regarding newly graduated RN practice readiness in the Australian context from the perspectives of key stake-holders, namely NUMs and BNPCs.

Chapter Summary

In summary, this necessary but relatively brief preliminary literature review highlighted a spirited debate indicating a difference in opinion as to whether recently graduated RNs are, in fact, practice ready.

The chapter set the scene and placed the inquiry in context. It presented significant background information including the forecasted nursing shortage, the pressing need for fiscal responsibility as a result of wide sweeping budget cuts, and the inability of hundreds of graduate RNs in Australia to secure employment each year. Such factors contextualised an examination of the perspectives of NUMs and BNPCs regarding newly graduated RN practice readiness in the Australian context.

The significance of understanding practice readiness from the perspectives of key stake-holders was elucidated through the discussion presented above. *Chapter Three*, which follows, continues to build the thesis by presenting a detailed description and justification of the methodology and methods used within the study.

CHAPTER THREE

RESEARCH DESIGN: METHODOLOGY AND METHODS

Introduction

Chapter Three discusses the underlying research paradigm and methodology for this study, namely Grounded Theory. This chapter is divided into two sections. Section one describes the methodology used to inform and guide the research. Section two describes the methods used to collect and analyse data. The second section includes sampling and recruitment of participants, memo writing, and also addresses ethical considerations. Considerations regarding credibility and transferability are also explored and key points are summarised at the end of the chapter.

Research Paradigm

A paradigm is a ‘worldview, a general perspective on the complexities of the world’ (Polit & Beck 2012, p. 11). This research utilised a qualitative inductive worldview with a Grounded Theory methodology to examine the perspective of NUMs and BNPCs regarding newly graduated RN practice readiness.

As highlighted by Roberts and Taylor (2002, p. 15), ‘qualitative research is interested in questions that involve human consciousness and subjectivity, and value humans and their experiences in the research process’. The aim of

qualitative research is to gain a thorough understanding of particular phenomena within certain contexts (Grbich 1999). According to Strauss and Corbin (2008, p. 16), the most important reason for choosing to conduct a qualitative research study is ‘the desire to step beyond the known and enter into the world of participants, to see the world from their perspective’ and in doing so contribute to the development of empirical knowledge. Polit and Beck (2012, p. 11) note that the research paradigm usually encompasses responses to philosophical questions such as ‘what is the nature of reality? (ontologic) and what is the relationship between the inquirer and those being studied? (epistemologic)’. Baldwin (2014) argues that the way researchers view the world influences the way they conduct their inquiry. Baldwin (2014) suggests that in the first instance, researchers should therefore identify their own philosophical stance.

At the outset of this study, the researcher engaged in thorough reflection on how she views the world and considered such ontologic and epistemologic questions to identify her personal philosophical position. Valuing humans and their experiences, the researcher wished to gain an understanding of a social phenomenon of interest, within a certain context, from the perspective of the people involved. This led to the researcher choosing an inductive qualitative approach. Given the longstanding debate indicating a difference in opinion as to whether recently graduated RNs are in fact practice ready, the social phenomenon of interest for this thesis is represented in the perspective of NUMs and BNPCs regarding graduate RNs practice readiness in the Australian context.

In this study, it is the NUMs and BNPCs perspectives that were explored and it is their voices and experiences that were privileged. This approach resulted in the generation of a substantive theory that is firmly grounded in the data being investigated. The discussion that now ensues demonstrates the ontological and epistemological underpinnings of the study leading to the emergence of the substantive theory.

Methodology

Deciding on the study

According to Schneider et al. (2013), a research methodology represents a framework for thinking about and conducting a research study. However, when presenting a research study, researchers usually present the final product and pay little attention to the processes they initially undertook to guide the selection of their key methodological approach (Lauckner, Paterson & Krupa 2012). In a recent paper, Lauckner, Paterson and Krupa (2012) outlined the journey undertaken by the first author as a PhD student, to identify a series of questions that guided her methodological choices. The first two questions are: *'1. What do I want to better understand? and 2. How do I best frame my research question to ensure I am gathering data that will inform this main concern?'* (Lauckner, Paterson & Krupa 2012, p. 3). Reading this paper motivated the researcher in this study, also a PhD student, to reflect on her own experience in the initial stages of her PhD journey and depict what helped shape her key methodological choices.

In one of the initial meetings with her academic supervisors, the researcher was invited to reflect on an area of interest and to specifically identify an area that she wished to understand better. The researcher expressed interest in exploring the issue of graduate RNs' practice readiness. The catalyst for this was her professional role as a nurse educator with a focus on managing undergraduate nursing clinical placements and the graduate RN transition programme within her health service.

So a process of reflection and brainstorming followed to identify a research topic. Initially, the researcher considered exploring the views and experiences of graduate RNs or the views and experiences of preceptors who work with graduate RNs regarding their practice readiness. However, the researcher was also aware of the multiple Australian and international studies that had already been undertaken exploring this issue from the perspective of graduates (Gerrish 2000; Malouf & West 2011; Marks-Maran et al. 2013; Parker, Plank & Hegney 2003; Parker et al. 2014; Watt & Pascoe 2013) and also preceptors (Hickey 2009; Muir et al. 2013; Panzavecchia & Pearce 2014). Therefore it became apparent that conducting a similar study would not contribute new knowledge to this debate.

As alluded to in *Chapter One*, the researcher was also cognisant of the longstanding debate relating to undergraduate nursing education and conjecture regarding newly graduated RN practice readiness. Such debate highlights the seemingly difference in opinion between the health industry and the higher education sector regarding the practice readiness of newly graduated RNs.

Given the researcher's professional role and experience as discussed in *Chapter One*, she was intrigued by such longstanding debate. Therefore, exploring the perspective of representatives of both the practice and education sectors in Australia regarding newly graduated RN practice readiness, as this research does, was warranted and would address this knowledge gap. It also, quite frankly, excited the researcher and ignited the flame of inquiry. Specifically, the researcher wished to understand what NUMs and BNPCs had to say about the issue. No one had asked them before!

The discussion that follows reveals how the researcher rationalised the selection of Grounded Theory as the ideal methodology to explore the perspective of NUMs and BNPCs regarding newly graduated RN practice readiness within the Australian context.

Why Grounded Theory?

Although Grounded Theory originated in sociology, it is a very popular qualitative research design not just in nursing but also across a wide range of disciplines (Cutcliffe 2005; Birks & Mills 2011; Gibson & Hartman 2014; Stern & Porr 2011; Urquhart 2013). Grounded Theory research aims to explore a social phenomenon of interest based on human interaction and to systematically generate comprehensive explanations of these patterns leading to a substantive theory grounded in reality through the data being investigated (Charmaz 2006; Gibson & Hartman 2014; Glaser & Strauss 1967; Stern & Porr 2011; Strauss & Corbin 2008; Urquhart 2013). Furthermore, Grounded Theory aims to generate a

substantive theory that accounts for the basic social process, which represents a pattern of behaviour relevant to those involved (Glaser 2005). The basic social process is labelled as a gerund, which explains ‘what is going on in the data’ (Glaser 1978, p. 94). Given that its philosophical underpinnings stem from sociology, Grounded Theory research is rooted in the theoretical perspective of symbolic interactionism (Cutcliffe 2000; Derbyshire, Machin & Crozier 2015). It offers a systematic approach to exploring the shared understanding of what is happening in relation to the social phenomenon being investigated ‘from the perspective of those involved and allows whatever is theoretically relevant to emerge’ (Andersen, Inoue & Walsh 2013, p. 3).

Walker and Myrick (2006, p. 557), describe Grounded Theory as ‘a complete package of procedures, techniques, and assumptions related to the discovery of practical theory’. Stern and Porr (2011) suggest that most Grounded Theory research effectively generates substantive theory. Differentiating between formal theory and substantive theory, Glaser and Strauss (1967) explain that substantive theory is a pragmatic explanatory theory developed for the purpose of understanding a specific social phenomenon or social pattern. Formal theories on the other hand, are developed to a higher level of conceptualisation and are usually applicable across a wide number of substantive areas (Birks & Mills 2011). Given that Grounded Theory research aims to investigate a social pattern from the perspective of the people involved (Glaser 1998), it was considered an ideal methodology for this research.

Furthermore, Grounded Theory is also considered an ideal methodology when not much is known on the topic of interest (Birks & Mills 2011; Creswell 1998). The paucity of research on this particular topic in Australia supported the justification of why Grounded Theory was considered a suitable methodology for this inquiry. This justification will be discussed further within this chapter.

Evolution of Grounded Theory

Grounded Theory methodology was originally founded in the 1960s by two sociologists Barney Glaser and Anselm Strauss as a reaction against the extreme positivist approach that became prevalent in social research (Suddaby 2006). As a process for researching social patterns, the aim of Grounded Theory was the development of a pragmatic substantive theory that is firmly grounded in the real-life data being investigated (Glaser & Strauss 1967).

The publication of their seminal work *The Discovery of Grounded Theory* (Glaser & Strauss 1967) was considered a breakthrough at a time when the research community was sceptical about qualitative methodology. Combining Strauss's background in social science and Glaser's background in quantitative research, they presented a systematic approach to conducting qualitative research (Holton 2009). Glaser and Strauss argued that 'qualitative research is a field of inquiry in its own right, not merely useful for pre-studies to "real" statistically based methods of inquiry' (Hallberg 2006, p. 142). Hence, Grounded Theory methodology is concerned with generating theories or hypotheses rather than

simply testing them (Birks & Mills 2011; Gibson & Hartman 2014; Glaser & Strauss 1967; Urquhart 2013).

An academic discord between Glaser and Strauss emerged in 1990, following the publication of Strauss and Corbin's text *Basics of Qualitative Research: Grounded Theory Procedures and Techniques* (Birks & Mills 2011; Gibson & Hartman 2014; Heath & Cowley 2004; Urquhart 2013; Walker & Myrick 2006). It was reported that Glaser found this book 'too prescriptive, irksome, and in violation of the quintessential nature of grounded theory' (Stern & Porr 2011, p. 19). Indeed, Glaser refuted Strauss' approach in his book titled *Emergence vs. Forcing: Basics of Grounded Theory Analysis* (1992) and accused Strauss and Corbin of 'having betrayed the common cause of Grounded theory' (Kelle 2005, p. 9). Furthermore, Glaser (1998, p. 32) cautions researchers that there is no need 'to force meaning on a participant, but rather a need to listen to his genuine meanings, to grasp his perspectives, to study his concerns'.

Polit and Beck (2012, p. 569) explain that the initial discord between Strauss and Glaser 'mainly concerns the manner in which the data are analyzed' and has resulted in two versions of Grounded Theory, namely 'Glaserian' and 'Straussian'. Walker and Myrick (2006, p. 547) also suggest that the division between Glaser and Strauss seems to be 'centred on the researcher's role, activity, and level of intervention in relation to the procedures used within the data analysis process'.

The unrelenting emphasis on the 'emergence of theory from data remains the subtle feature which distinguishes Glaser's approach' to Grounded Theory from

other researchers (Duchscher & Morgan 2004, p. 606). Duchscher and Morgan (2004, p. 605) use the following comparison to further explain the philosophical discord between Glaser and Strauss in relation to the emergence versus forcing debate:

... compare Glaser's model of theory generation, where theory rises directly and rigorously out of the data, devoid of interpretivism, to Strauss's conceptually descriptive approach that encourages directive questioning and supports an interpretive stance.

Due to its popular use, Grounded Theory has evolved and will no doubt continue to evolve since its development by Glaser and Strauss in the 1960s. Further evolution by second generation grounded theorists (Charmaz 2006), led to a constructivist approach. Charmaz (2006) acknowledges the role of the researcher and its influence over the research process.

To date, three distinct versions of Grounded Theory have emerged since its initial inception in 1967; namely the Glaserian Grounded Theory '(labelled "classic" GT by Glaser and his advocates)', the Straussian Grounded Theory and the constructivist Grounded Theory developed by Charmaz in 2000 (Thornberg 2012, p. 244). As such, it is imperative that researchers have a thorough understanding of the divergent approaches to Grounded Theory and to be able to justify the approach they plan on using (Heath & Cowley 2004).

This research used a classic Grounded Theory approach. An exploration of the divergent Grounded Theory approaches and the rationale for using the classic approach will be further discussed in this chapter. But firstly, it is important to consider the philosophical links between Symbolic Interactionism and Grounded Theory.

Symbolic Interactionism

Grounded Theory research is rooted in the theoretical perspective of symbolic interactionism as it aims to explore social patterns from the perspective of people involved (Cutcliffe 2000; Derbyshire, Machin & Crozier 2015). The term ‘symbolic interactionism’ was coined by Blumer (1969) who adopted the teachings of George Herbert Mead (1934), the founder of social psychology. Blumer (1969, p. 5) explains that ‘symbolic interactionism sees meanings as social products, as creations that are formed in and through the defining activities of people as they interact’.

Symbolic interactionism is a theoretical perspective to study human behaviour within a social context (Chen & Boore 2009) and it ‘assumes society, reality, and self are constructed through interaction and thus rely on language and communication’ (Charmaz 2006, p. 7). According to Blumer (1969, p. 2), symbolic interactionism is based on the following three premises:

The first premise is that human beings act towards things on the basis of the meanings that the things have for them. ... The second premise is that the meaning of such things is derived from, or arises out of, the social interaction that one has with one's fellows. The third premise is that these meanings are handled in, and modified through, an interpretive process used by the person in dealing with the things he encounters.

Blumer (1969, p. 3) adds that meaning can be understood through examination of social patterns and ‘to ignore the meaning of the things toward which people act is seen as falsifying the behaviour under study’.

Hallberg (2006, p. 142) claims that ‘the ontological assumptions behind symbolic interactionism include that meaning is constructed and changed via interactions between people and that people act on the basis of the meaning they ascribe a situation’. Oliver (2012) suggests that meaning making in symbolic interactionism

is a social pattern. As maintained by Stern and Porr (2011, p. 29), symbolic interactionism combined with pragmatism underpin the internal workings of Grounded Theory, which then enable researchers to methodologically account for human action.

In this study, the social phenomenon of interest is the perspective of NUMs and BNPCs regarding graduate RN practice readiness in the Australian context. As expressed by Newman (2008, p. 105), the researcher in this study strived to find reality in the participants' experiences and opinions 'in evidence of patterns of phenomena that enables the conceptualisation of middle-range theory'. As such, the goal of this Grounded Theory study was to make sense of the perspective of NUMs and BNPCs regarding graduate RN practice readiness.

Such an exploration of the phenomenon of interest, from the perspective of the people involved, adds further support for the selection of Grounded Theory as the methodology of choice for this research.

Epistemological Discussion: Inclusion of Researcher

According to Glaser and Strauss (1967, p. 3),

... the researcher does not approach reality as a tabula rasa. He must have a perspective that will help him see relevant data and abstract significant categories from his scrutiny of the data.

Moreover, Glaser (2002a) asserts that the contribution of the researcher is not discounted within classic Grounded Theory and that the researcher bias is 'just another variable and a social product' (p. 3) and should be weaved into the constant comparative analysis. Glaser (2002a, p. 2) adds that Grounded Theory is

... a perspective based methodology and people's perspectives vary. ... Multiple perspectives among participants is often the case and then the GT researcher comes along and raises these perspectives to the abstract level of conceptualization hoping to see the underlying or latent pattern, another perspective.

Charmaz and Bryant (2010, p. 293) on the other hand, explain that constructivist Grounded Theory unlike earlier versions of Grounded Theory, 'accepts the notion of multiple realities ... and rejects assumptions that researchers should and could set aside their prior knowledge to develop new theories'.

In his book *The Grounded Theory Perspective*, Glaser (2001, p. 145) responds to the constructivist views of Charmaz and argues that:

'All is data' is a well known Glaser dictum. What does it mean? It means exactly what is going on in the research scene is the data, whatever the source, whether interview, observations, documents, in whatever combination. It is not only what is being told, how it is being told and the conditions of its being told, but also all the data surrounding what is being told.

Hunter et al. (2011) discuss the first author's choice and rationale for adopting classic Grounded Theory methodology for a higher research degree. They claim that he was initially drawn towards constructivist Grounded Theory that enables 'researchers to mirror their professional backgrounds by engaging with the participants and encouraging active influence over the outcomes of the research' (Hunter et al. 2011, p. 10). However, the authors argue that Glaser (2002a) has 'made the case for inclusion of self' in classic Grounded Theory as well as for engagement with participants through the 'rigour of constant comparative method along with theoretical sampling' (Hunter et al. 2011, p. 10). Also in support of the classic Grounded Theory approach, Breckenridge et al. (2012, p. 4), assert that 'privileging participants' main concerns over the professional concern of the

researcher ... strives to generate a theory that is useful, meaningful and relevant to participants’.

In this study, giving participants a voice and privileging their concerns over her professional interests and concerns (Breckenridge et al. 2012), was something that the researcher wanted to realise. By embracing the classic Grounded Theory approach, the researcher ensured that all data were inductively derived from the research process and therefore remained true to the perspectives of the participants (Breckenridge et al. 2012; Duchscher & Morgan 2004).

The Use of Literature

Delaying the use of the literature is another contentious feature of Grounded Theory methodology (Birks & Mills 2011; Gibson & Hartman 2014; Thornberg 2012; Urquhart 2013; Walls, Parahoo & Fleming 2010). Glaser and Strauss (1967) and Glaser’s later work (1998) argue that a formal review of the literature is delayed in grounded theory research to prevent contamination of the data collected and to ‘prevent the researcher imposing existing theories or knowledge on the study processes and outcomes’ (Birks & Mills 2011, p. 22). Glaser (1998) adds that the literature search in the substantive area should be undertaken and used as data for constant comparison only at the end of data analysis.

In contrast to the classic Grounded Theory tradition, Charmaz (2006) presents a constructivist grounded theory approach. Charmaz (2006) argues that ‘neither observer nor observed come to a scene untouched by the world’ (p. 15) and suggests (p. 10) that:

In the classic grounded theory works, Glaser and Strauss talk about discovering theory as emerging from data separate from the scientific observer. Unlike their position, I assume that neither data nor theories are discovered. Rather, we are part of the world we study and the data we collect. We construct our grounded theories through our past and present involvements and interactions with people, perspectives, and research practices.

Thornberg (2012, p. 246) concurs with Charmaz in that ‘empirical observation could never be totally free from theoretical influence because seeing is already a “theory-laden” undertaking’. However, he asserts that researchers should be able to review pre-existing knowledge and theories in the substantive field as long as they ‘remember that the main focus is on data, not on literature, and that every code, concept or theoretical idea ... must be grounded in data’ (Thornberg 2012, p. 252). Thornberg (2012, p. 253) also warns researchers that:

... extant theoretical concepts and ideas from literature in the substantive field have to earn their way into a GT in the same way as Glaser (1978, 1998, 2005) argues that theoretical codes must earn their way, i.e. by coding, constant comparison, theoretical sampling, memo writing, and memo sorting.

In relation to reviewing the literature, Walls, Parahoo and Fleming (2010) warn novice researchers that interpreting the position of classic grounded theorists literally might lead to misunderstandings. Urquhart (2013, p. 16) also contends that ‘having no preconceived theoretical ideas is often held (erroneously) to imply that researchers should not look at existing literature before doing the empirical research’. Stern and Porr (2011, p. 49) explain how Grounded Theory researchers need to ‘delve into the literature both before and during’ the research project to conduct a ‘primary review’ at the proposal stage and an ‘evolving review’ during the research process. They also add that ‘academic literature becomes data to be

analysed along with interviews, observational and documentary data' (Stern & Porr 2011, p. 50).

Regardless of the Grounded Theory approach adopted by researchers, a preliminary review of the literature is usually warranted to justify the need for the research study and determine 'the extent of current knowledge and work undertaken in the field', (Birks & Mills 2011, p. 22). This is especially so for higher degree by research given that the aim of the PhD is to generate new knowledge.

As alluded to in *Chapter Two*, only a cursory review of the literature was undertaken in the preliminary stages of this research, for two reasons. Firstly, it was necessary to confirm that the proposed research had not been undertaken in Australia and therefore would make a positive contribution to new nursing knowledge. Secondly, it contributed to the written detailed proposal for the university to enable confirmation of candidature as a PhD student.

Although familiar with the contemporary national and international discourse related to graduate RNs' practice readiness, the researcher abstained from undertaking a thorough review of the literature in the early stages of the research. This enabled the theory to emerge from the data rather than from pre-existing theoretical concepts as per Grounded Theory methodology. Once the categories and the theory had been sufficiently developed, the main review of literature was then undertaken in the substantive area (Urquhart 2013). This review is incorporated into the discussion, offered in *Chapter Five*.

Grounded Theory and this Research

Breckenridge et al. (2012, p. 1) acknowledge that novice researchers who decide to use Grounded Theory are faced with complex decisions regarding which approach to use ‘given the complexities of the inherent philosophical debates and the ambiguous and conflicting use of grounded theory’. Therefore, it is recommended that researchers embarking on Grounded Theory research familiarise themselves with the various approaches and consistently apply the approach that best fits their philosophical worldview and suits their research (Cutcliffe 2000; Duchscher & Morgan 2004; Hunter et al. 2011).

According to El Haddad, Moxham and Broadbent (2013), a significant number of graduate RNs are currently, and will increasingly, be required to join the workforce each year in response to the looming nursing shortage and the growing healthcare demands of an aging Australian population. Furthermore, the higher rate of job turnover of nurses in acute care hospitals as compared to community or rural healthcare settings (Hayes et al. 2006), suggests that the majority of graduate RNs ‘make their initial transition to professional practice within the hospital environment’ (Duchscher 2009, p. 1104).

In Australia, graduate RNs are declared competent practitioners at a novice level with the award of registration (McGrath et al. 2006). However, as alluded to earlier, the debate regarding graduate RN practice readiness continues to linger in Australia, and indeed globally (Cubit & Ryan 2011; Duchscher 2009; El Haddad, Moxham & Broadbent 2013; Evans, Boxer & Sanber 2008; Hinton & Chrigwin 2010; Kenny et al. 2012; Mannix, Wilkes & Luck 2009; Monaghan 2015; Newton & McKenna 2007; Parker et al. 2014; Romyn et al. 2009; Rush et al. 2015; Watt

& Pascoe 2013; Wolff, Pesut & Regan 2010). Such debate reflects a difference in opinion between nurses in education and practice sectors, as to whether recently graduated RNs are in fact practice ready (El Haddad, Moxham & Broadbent 2013).

This longstanding debate contributes to the significance of this research study and the desire of the researcher to explore the social phenomenon of interest that is the perspectives of NUMs and BNPCs regarding newly graduated RN practice readiness. Given the paucity of research on this particular topic in Australia and the desire of the researcher to develop a substantive theory that explains the social phenomenon of interest, Grounded Theory was considered a suitable methodology for this inquiry.

The Role of the Researcher

As described in *Chapter One*, the researcher in this study is a RN working as a nurse educator, having worked within the education sector and healthcare industry for over twenty-seven years both in Australia and overseas. Managing undergraduate nursing clinical placements and graduate RN programmes has become an increasingly significant focus of the researcher's professional role during the last sixteen years. As such, the researcher was cognisant of the local, national and international debate relating to undergraduate nursing education and graduate registered nurses' practice readiness. The impetus for this research originated as a result.

The researcher's prior experience may be considered by some as a source of bias. There is no doubt that the researcher has opinions, all researchers do when they enter the field of research (Charmaz 2006; Gibson & Hartman 2014; Glaser 1998; Glaser & Strauss 1967; Urquhart 2013). After all, no researcher could enter the field devoid of past knowledge or experience (Heath & Cowley 2004; Suddaby 2006). Gibson and Hartman (2014, p. 35) explain that 'the distinction we are looking at here is the distinction between *using preconceived notions* and *having preconceived notions*. Doing research without having preconceived notions is of course impossible'.

According to Heidegger (1927/1962 as quoted by Lavery 2003, p. 8), 'pre-understanding is a structure for being in the world ... pre-understanding is not something a person can step outside of or put aside'. Similarly, Schreiber and Stern (2001) suggest that researchers cannot unlearn what they already know. While acknowledging this fact, Glaser (1998) stresses that researchers need to come into the research with an open mind. Furthermore, Bruce (2007) and Gibson and Hartman (2014) advocate the need for researchers to maintain a transparent outlook regarding their underlying assumptions and theoretical understandings to minimise researcher bias.

In this study the researcher followed the above advice by Glaser (1998), Bruce (2007) and Gibson and Hartman (2014) to minimise researcher bias throughout her study. This led to constant reflection, with the researcher continually exploring her own views and existing knowledge on the topic. Strategies employed included the writing of regular memos, peer discussion and review with other PhD students and through regular meetings with her supervisors to reflect,

consider and debate. These reflections, notes, memos etc. were then woven into the constant comparative analysis as data. After all, Glaser (2002a, p. 3) asserted that:

... bias is just another variable and a social product. If the researcher is exerting bias, then this is a part of the research, in which bias is a vital variable to weave into the constant comparative analysis. It happens easily in “hot” or “passionate position” issue orientated research ...

The inductive approach of Grounded Theory gave the researcher a unique opportunity to allow the data to inform the emergence of the substantive theory in this study. After all, the researcher’s prior experience and knowledge of the substantive area being investigated enabled her to appreciate the nuances and understand the subtlety of what was being said by participants ‘in the field and in the analysis of the data’ (Walls, Parahoo & Fleming 2010, p. 11).

The previous section of the research design chapter provided an explanation and rationale for the use of the methodological approach, namely classic Grounded Theory. The following section details the methods used to conduct this study.

Methods

According to Andrews et al. (2012, p. 14), the methods used in Grounded Theory offer a ‘rigorous, orderly guide for theory development’. Charmaz (2006 p. 9) describes methods in Grounded Theory ‘as a set of principles and practices, not as prescriptions or packages’. She adds that these ‘methods consist of systematic, yet flexible guidelines for collecting and analysing qualitative data to construct theories ‘grounded’ in the data themselves’ (Charmaz 2006, p. 2). Stern and Porr

(2011) also argue that Grounded Theory is not about following a rigid formula and that principles such as ‘discovery never verification, explanation never description, emergence never forcing’ (p. 39) are fundamental to the success of Grounded Theory studies. According to Glaser (1978, 1992, 1998), the main features of classic Grounded Theory research include initial purposeful sampling followed by theoretical sampling; constant comparative analysis; open, selective and theoretical coding; theoretical sensitivity; theoretical saturation and memoing.

The discussion that follows outlines the specific methods that were implemented throughout this Grounded Theory study. While implementing these methods, the researcher adhered to the above mentioned principles discussed by Stern and Porr (2011) and to the main features of classic Grounded Theory outlined by Glaser (1978, 1992, 1998). The discussion will include a description of the population and sampling, participant recruitment, data collection and analysis techniques as well as ethical considerations that every research study involving humans should be cognisant of.

Population and Sampling

According to Polit and Beck (2008, p. 337), ‘a population is the entire aggregation of cases in which a researcher is interested’. This research study required the views and opinions of NUMs and of BNPCs in Australia regarding graduate RN practice readiness. Hence, a purposive sampling method was used by the researcher to recruit participants from higher education institutions, which is referred to as the education sector and from acute healthcare settings, which is

referred to as the practice sector in this thesis. Purposive sampling is a deliberate selection of a group of participants who are typical of the population with particular knowledge of the topic of interest and can best inform the research (Liamputtong 2009; Polit & Beck 2012; Schneider et al. 2013).

As this research examined the perspective of NUMs and BNPCs regarding newly graduated RN practice readiness within the Australian education and practices sectors, the participants were therefore required to meet the following inclusion criteria:

a) NUMs, who work in acute hospital settings in Australia and who employ and manage graduate RNs.

b) BNPCs from accredited universities across Australia.

These two groups were selected as the purposive sample for this study for the following reasons:

NUMs in acute hospital setting: Given that the majority of graduate RNs continue to be initially employed within acute care hospitals (Duchscher 2009) rather than other clinical settings, NUMs in acute hospital settings were selected as one purposive cohort for this study.

Several recent Australian studies that explored students' career choices revealed that the majority of students continue to pursue a career in acute care settings as a preference rather than in aged care and primary healthcare settings (Birks, Al-Motlaq & Mills 2010; Bloomfield et al. 2015; Hickey & Harrison 2013; Stevens 2011) or in mental health (Stevens, Browne & Graham 2013). This might be due

to the higher rate of job turnover of nurses in hospitals as compared to community, aged care or rural healthcare settings (Hayes et al. 2006).

It is not clear if this trend is due to the lack of positions offered for newly graduated RNs in aged care or primary healthcare settings, the lack of sufficient transition programmes in such settings or simply due to other reasons. Other possible reasons for this trend might include the autonomous nature of the RN role in community settings where they are required to make independent clinical decisions (Peters, McInnes & Halcomb 2015).

Such trend remains in place despite the changing landscape of healthcare in Australia and the calls to strengthen the role of primary healthcare nursing (Aged & Community Services Australia 2010; Productivity Commission 2011). This is significant given the ongoing changes in healthcare focus and delivery in Australia and globally and given that the ‘balance of care is shifting from hospital based care to care in the community’ (Holland & Lauder 2012, p. 63). However, despite such global changes, the majority of graduate RNs continue to be initially employed within acute care hospitals (Duchscher 2009) rather than in aged care or primary care settings (North, Leung & Lee 2014; Olson 2009). This trend was corroborated by participants in this study.

In 2011, approximately one-quarter (26% percent or 44,654) of clinical RNs in Australia worked in medical, surgical and mixed medical/surgical areas (HWA 2013). Furthermore, the report titled *Nursing and Midwifery Workforce 2012* reveals that 125,094 out of a total of 188,158 registered nurses, who were employed in a clinical role across Australia in 2011, were working in a hospital

setting (AIHW 2013c). This validates the proclamation that the highest percentages of the RN workforce identified in a clinical role in Australia continue to be employed within acute care hospitals (AIHW 1999, 2013c; HWA 2013). This is depicted in Figure 6 and Table 3 below.

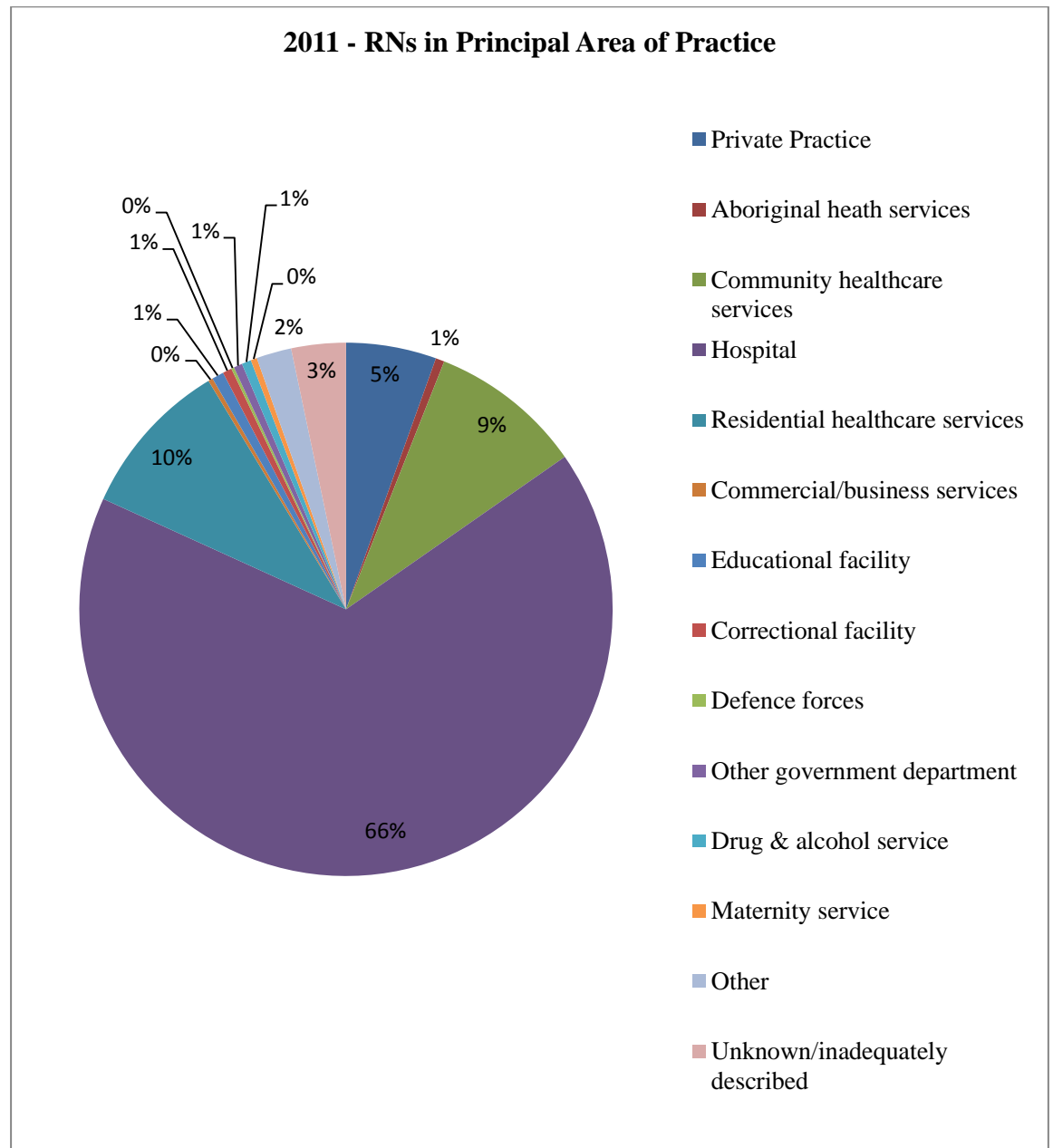


Figure 6: Percentage of RNs in principal area of practice in Australia in 2011 (AIHW 2012)

Table 3: Number of RNs in principal area of practice in Australia in 2011 (AIHW 2012)

PRINCIPAL AREA OF PRACTICE	NUMBER
Private practice	10,302
Aboriginal health service	995
Community health care services	17,511
Hospital	125,094
Residential health care services	18,026
Commercial/business service	526
Educational facility	1,348
Correctional service	1,038
Defence forces	326
Other government department or agency	983
Drug and alcohol service	1,077
Maternity service	713
Other	3,999
Unknown/inadequately described	6,219
Total	188,158

As such, NUMs in acute care practice in hospital settings, who manage graduate RNs, were selected as one cohort of the purposive sample. Persons incumbent in those positions are usually:

- In charge of clinical wards/units where graduate nurses are employed
- Involved in staff recruitment and support
- Involved with staff performance appraisal
- Responsible at ward/unit level for patient care and safety
- Responsible at ward/unit level to ensure a safe work environment for staff
- Responsible at ward level for the human, physical and financial resources of the ward/unit

According to New South Wales Health (NSW Health 2010, p. 1), the NUM role is critical to the ward management and leadership, ‘to ensure the delivery of high quality patient care and efficient use of resources’. Given the attributes identified above, Duffield et al. (2007) summarises the NUMs’ role as being responsible for contributing to nurses’ job satisfaction at ward level by providing good nursing leadership. Hogan, Moxham and Dwyer (2007, p. 198) highlight the significant role NUMs play to alter organisational culture and argue that ‘positive relationships with NUMs can create greater job satisfaction and organizational commitment’ among the nursing workforce.

The second cohort deemed necessary to inform this study, were BNPCs. Persons incumbent in those positions possess:

- an in-depth understanding of bachelor of nursing programmes, especially in relation to content relevance and currency.
- an in-depth understanding of the bachelor of nursing programme accreditation requirements.

- responsibility for developing, embedding and monitoring learning outcomes and graduate attributes within the programme.
- responsibility for developing and monitoring effective teaching strategies.
- responsibility for dealing with programme issues and challenges.

(University of the Sunshine Coast 2014)

Graneheim and Lundman (2004) suggest that the selection of participants with experiences that enable them to offer insights into the research topic of interest is critical to the credibility of qualitative research. Hence, the selection of NUMs and BNPCs as participants for this study, who were able to offer great insights into this research topic, contributes to the credibility of this study. The following discussion will explain how participants were recruited.

Participant Recruitment

Participant recruitment and data collection began only after ethical clearance was granted from the universities' Human Research Ethics Committee (HREC) (Approval number: H11/05-090 & HE12/356). Two HREC clearance numbers are identified here as the researcher commenced at one university with her principle supervisor, but when her supervisor moved to the University of Wollongong, the researcher wished to remain with her supervisor and duly transferred. Subsequent to ethical clearance, potential participants who fulfilled the inclusion criteria were invited to partake in this research through a recruitment campaign.

This campaign involved several strategies. Firstly, the research developed an information sheet outlining the purpose of the study and the contact details of the

researcher. In accordance with the *National Statement on Ethical Conduct in Human Research* by the National Health and Medical Research Council (NHMRC 2007), this information sheet was written in plain language. A copy of which can be seen in Appendix 1. One strategy to recruit both NUMs and BNPCs involved leaving copies of the information sheet at three national nursing education conferences.

Another strategy involved advertising in an Australian professional nursing journal. Further to this, BNPCs were invited directly through their work e-mail addresses. A copy of the information sheet was forwarded to BNPCs in every university in Australia that offered an accredited BN programme with details for contacting the researcher, inviting them to participate in this study. The first strategy yielded the most number of participants and the combination of all strategies resulted in a geographic spread of respondents from 5 out of 8 Australian States and Territories. Figure 7 below, illustrates the process of participant recruitment, which was followed in this study.

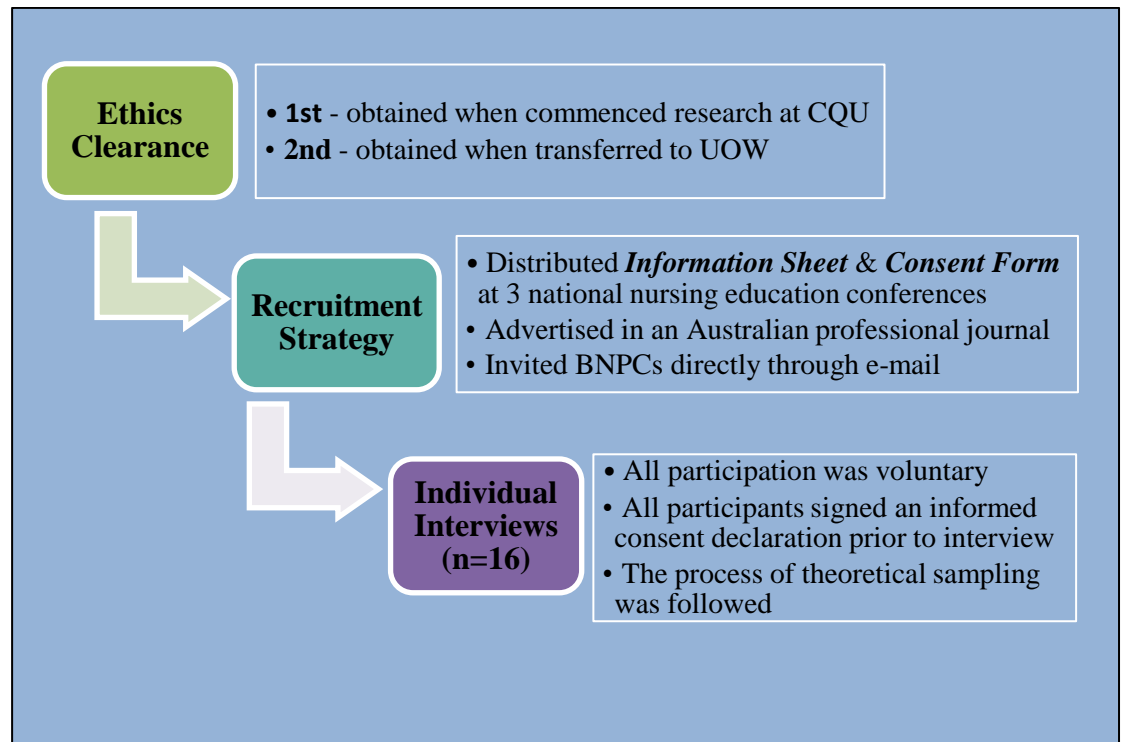


Figure 7: Participant recruitment

Some NUMs and BNPCs indicated their interest in participating in the study by approaching the researcher at the three conferences. Others indicated their interest by emailing or calling the researcher as suggested in the information sheet. The researcher then contacted all interested participants who matched the inclusion criteria, ensured they were informed of the purpose of the study and made appointments for each interview.

Detailed demographic data was perceived to not contribute additional insight and therefore only limited demographic data was collected. Furthermore, individual participants were not identified or described in any detail to ensure there is no risk of revealing their identity in line with the National Health and Medical Research Council (NHMRC 2007) statement on ethical conduct in human research. The

initial process of purposeful sampling followed by theoretical sampling led to a total of sixteen participants taking part in this study nationally. All participants in this study signed an informed consent declaration prior to commencing data collection (Appendix 2). Out of the sixteen participants, seven were NUMs and nine were BNPCs as illustrated in Figure 8 below.

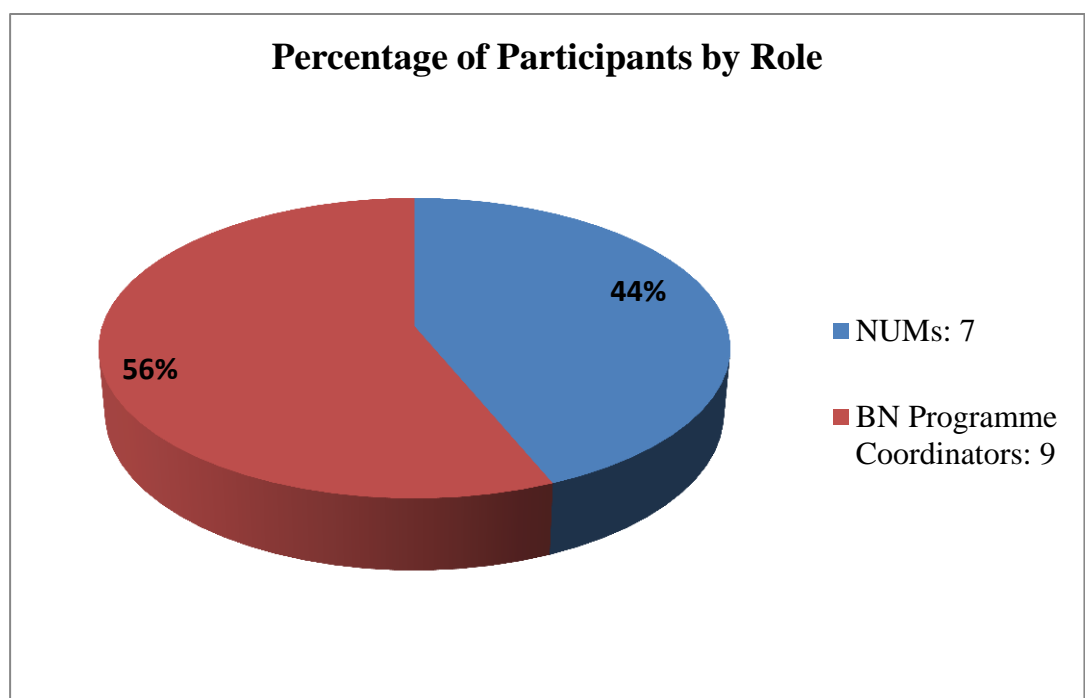


Figure 8: Percentage of participants by role

The researcher adhered to Grounded Theory methods where the sample size is not pre-determined but is influenced by theoretical saturation of the data. The process of how the data were collected is discussed next.

Data Collection

In Grounded Theory, researchers are compelled to engage with participants to explore their interpretations of what is happening and ‘their explanations of the how, why, when and where of what they and others are doing or experiencing’ (Stern & Porr 2011, p. 42).

This research was concerned with examining the perspectives of NUMs and BNPCs regarding newly graduated RN practice readiness in the Australian context. Therefore, it was paramount that the data collected by the researcher represented the participants’ opinions and views on the topic being investigated. The study did not set out to generalise results or quantify opinion. As such, in-depth semi structured interviews were the method of choice for primary data collection. A suitable date and time was negotiated with participants for each individual interview, which was held either face-to-face or via telephone.

This ‘conversational’ method enabled participants to elaborate on responses (Schneider et al. 2013) and the researcher to clarify and check for understanding during the interview (Charmaz 2006). According to Novik (2008), interviewing is quite a skill whether by phone or face-to-face. There is a general assumption in social science research that ‘the most appropriate method for producing narrative data is through face-to-face encounters with participants’ (Holt 2010, p. 114). Furthermore, being unable to see participants and read their non-verbal cues along with any long silences over the phone is believed to contribute to the researcher feeling uncertain about whether the participant has finished speaking (Holt 2010; Novik 2008; Shuy 2001; Stephens 2007; Sturges & Hanrahan 2004; Wallace 2005).

In a study utilising telephone interviews for primary data collection, Holt (2010, p. 118) highlighted the ‘interactional difficulties in a research encounter where the researcher is deliberately reticent and where there are no visual cues to compensate for this reticence’. Holt (2010, p. 118) added that as a researcher:

I wanted to avoid directing the narrative with my own interjections while at the same time I needed to let the participants know that I was still present and listening. ... I attempted to resolve this by interjecting the narrative with lots of ‘umms’ and ‘ahhs’ and ‘yes’s’.

In the same study, Holt (2010) suggested that telephone interviews should not be considered ‘second best’ (p. 117) and that ‘the success of the telephone narrative interview is likely to depend on the telephone skills of the researched as well as the researcher’ (p. 118). Flexibility is acknowledged as one of the benefits associated with telephone interviews where the location or time of interview were able to be moved to control the privacy of the conversation or for convenience of either participant or researcher (Holt 2010; Stephens 2007; Trier-Bienkiew 2012).

Given that participants came from all over Australia, telephone interviews provided the researcher with an efficient and fiscally responsible approach for primary data collection. Figure 9 provides an illustration that portrays the vastness of the Australian continent, which encompasses six States and two Territory jurisdictions. Travelling across the country of almost eight million square kilometres to interview participants in person would have been a logistical challenge and a very costly and time consuming endeavour. Something that a PhD study, which sits within a Research Training Scheme (RTS) cannot accommodate.



Figure 9: Comparison of relative size of Australia to the USA and Canada (reddit.com)

In this study, and due to the tyranny of distance involved between States and Territories in Australia, face-to-face interviews occurred only on four occasions and in the early stages of data collection. Nonetheless, the researcher was able to draw on her experience from the initial face-to-face interviews, her reflection on Holt's (2010) experience and her discussion and practice with her research supervisors. This enabled the researcher to manage any long silences over the phone and to carefully conduct the interviews without interrupting participants or breaking their train of thought.

In-depth interviewing is regarded as the prime method for qualitative data collection in general (Schneider et al. 2013) and the most common data collection method for a Grounded Theory study (Polit & Beck 2012; Stern & Porr 2011). This data collection method enables participants to elaborate on their responses and/or seek clarification throughout the interview (Schneider et al. 2013). It also enables the researcher to clarify a participant's response and check for understanding during the course of the interview (Charmaz 2006). Moreover, conducting individual interviews at a time convenient for each participant optimises confidentiality and enables participants to talk freely and disclose their opinions without feeling judged, distracted or lead by others, which may occur when other participants are present (Charmaz 2006).

Furthermore, in-depth semi structured interviews allow researchers to use open-ended questions and insert 'probes designed to elicit more detailed information' (Polit & Beck 2008, p. 394). Open ended questions enable participants to challenge existing beliefs and practices and to consider different options in relation to the study at hand (Peavey 2000). This is directly opposite to closed questions, such as those used in surveys that elicit a closed answer and capture a limited response (Alreck & Settle 1995). The use of in-depth interviewing as the most appropriate method for data collection also contributes to the credibility of this research as it enabled the researcher to elucidate the views and opinions of the participants regarding the topic of interest (Graneheim & Lundman 2004).

On average, each individual interview lasted 45 minutes. These interviews were not hurried and they concluded naturally when participants indicated that they had no more to say in relation to the topic of discussion (Schneider et al. 2013). The

interviews were digitally recorded and transcribed verbatim soon after, to enhance data analysis (Grbich 1999). According to Grbich (1999), the recording of interviews enhances accuracy in data collection, minimises the need to rely on memory and prevents the researcher and participant from being distracted during the interview. Transcribing interviews as soon as possible after each interview enabled the researcher to engage in immediate and concurrent data analysis, which led to further theoretical sampling and data collection as per constant comparative analysis method (Birks & Mills 2011). The questions for collecting data and the data analysis techniques used in this research are now discussed in the following sections.

Questions Used to Collect the Data

As discussed earlier, the overarching research question that guided data collection for this study was *‘what are the perspectives of NUMs and BNPCs regarding the practice readiness of newly graduated RNs?’*

According to Stern and Porr (2011, p. 53), ‘it takes respect, sensitivity, humility, curiosity and tremendous skill to elicit information from complete strangers’. These researchers add that minimising assumed differences, enhances the transfer of valuable information between interviewer and respondent (Stern & Porr 2011).

In this study, the researcher treated all participants with respect, sensitivity and humility, informing them of who she was at the outset of the interview so as to minimise assumed differences and to present her human side (Stern & Porr 2011). This assisted with the development of rapport and trust and facilitated open and

honest discussion. It is also important to note that all participants volunteered and consented to be involved.

When considering the interview questions, the researcher consistently followed Glaser's (1992, p. 22) dictum that researchers should move in 'with the abstract wonderment of what is going on that is an issue and how it is handled'. Over the years, this question has become a 'famous Grounded Theory mantra' (Birks & Mills 2011, p. 5). The researcher opened the interview with the following broad statement to commence the discourse: *'I would like to talk with you about your understanding regarding newly graduated RNs' practice readiness'*, followed by the broad question of: *What is going on in your opinion that is an issue?'*

Broad opening questions are often referred to as "grand tour" questions, which ask participants to 'give a verbal tour of something they know well' and it gets them talking, but in a rather focused way (Leech 2002, p. 667). Most participants expressed their views freely and openly in relation to the topic of study and did not require a lot of prompting. However, a small number did require additional probing questions.

Wimpenny and Gass (2000 p. 1489) suggest that in Grounded Theory 'ongoing analysis will influence the questions that are asked, with the direction of the interview becoming driven by the emerging theory (theoretical sampling)'. Therefore, endeavouring not to lead the discussion (Schneider et al. 2013), and guided by the participants' responses and emerging theory (Cutcliffe 2005; Glaser 1992), the researcher posed further open-ended questions and used probes to elicit even richer responses. These questions endeavoured to 'stimulate more reflective

thinking and a deeper level of conversation' (Vogt, Brown & Isaacs 2003, p. 4). The following is an illustration of the type of questions that provided a catalyst to enable deeper probing as the interviews progressed:

- *Please describe a typical graduate RN.*
- *What do you think a graduate RN should be able to do?*
- *What do you think the attributes of a graduate RN should be?*
- *When do you think a graduate RN should attain such attributes?*
- *What makes a graduate RN practice ready?*
- *What do you think impacts the graduate RNs' practice readiness?*
- *What do you think contributes to graduate RNs' practice readiness?*
- *How do you think, as a NUM or BNPC, you contribute to graduate RNs' practice readiness?*
- *How do you see the way forward in relation to the issue of graduate RNs' practice readiness?*
- *Is there anything else that you would like to add before we end this interview?*

In Grounded Theory research, questions evolve in subsequent interviews to reflect the emerging themes and categories during the ongoing analysis of the data being investigated (Cutcliffe 2005; Glaser 1992; Stern & Porr 2011; Wimpenny & Gass 2000). In this study, and in addition to the above listed questions, the researcher asked more explorative questions regarding specific issues related to the emerging themes. For example, in subsequent interviews, participants' views were explored

regarding the BN curricula; contextual enculturation; and financial considerations related to clinical placements of students and the support of novice graduates.

Data Analysis

In Grounded Theory, data collection and data analysis occur concurrently from the beginning of the study in a process termed, constant comparative analysis (Gibson & Hartman 2014; Stern & Porr 2011). With regard to data analysis, it is important to remember that Grounded Theory, as asserted by Glaser (2002a, p. 2), is:

... a perspective based methodology and people's perspectives vary. ... then the GT researcher comes along and raises these perspectives to the abstract level of conceptualization hoping to see the underlying or latent pattern, another perspective.

The following steps were applied in this study to collect and analyse the data leading to the conceptual emergence of a substantive theory:

- initial purposeful followed by theoretical sampling
- initial coding
- concurrent data collection and analysis
- coding and categorising
- memoing and theoretical sensitivity
- refining categories
- refining and connecting categories
- emergence of core category
- further refining and connecting categories

- theoretical saturation
- emergence of substantive theory

Figure 10 below illustrates the processes of data collection and analysis that were applied in this study. The constant comparative analysis method; the coding process; theoretical sampling; theoretical sensitivity; theoretical saturation and memoing are now discussed in more detail in the following sections. This discussion commences with the section on constant comparative analysis method.

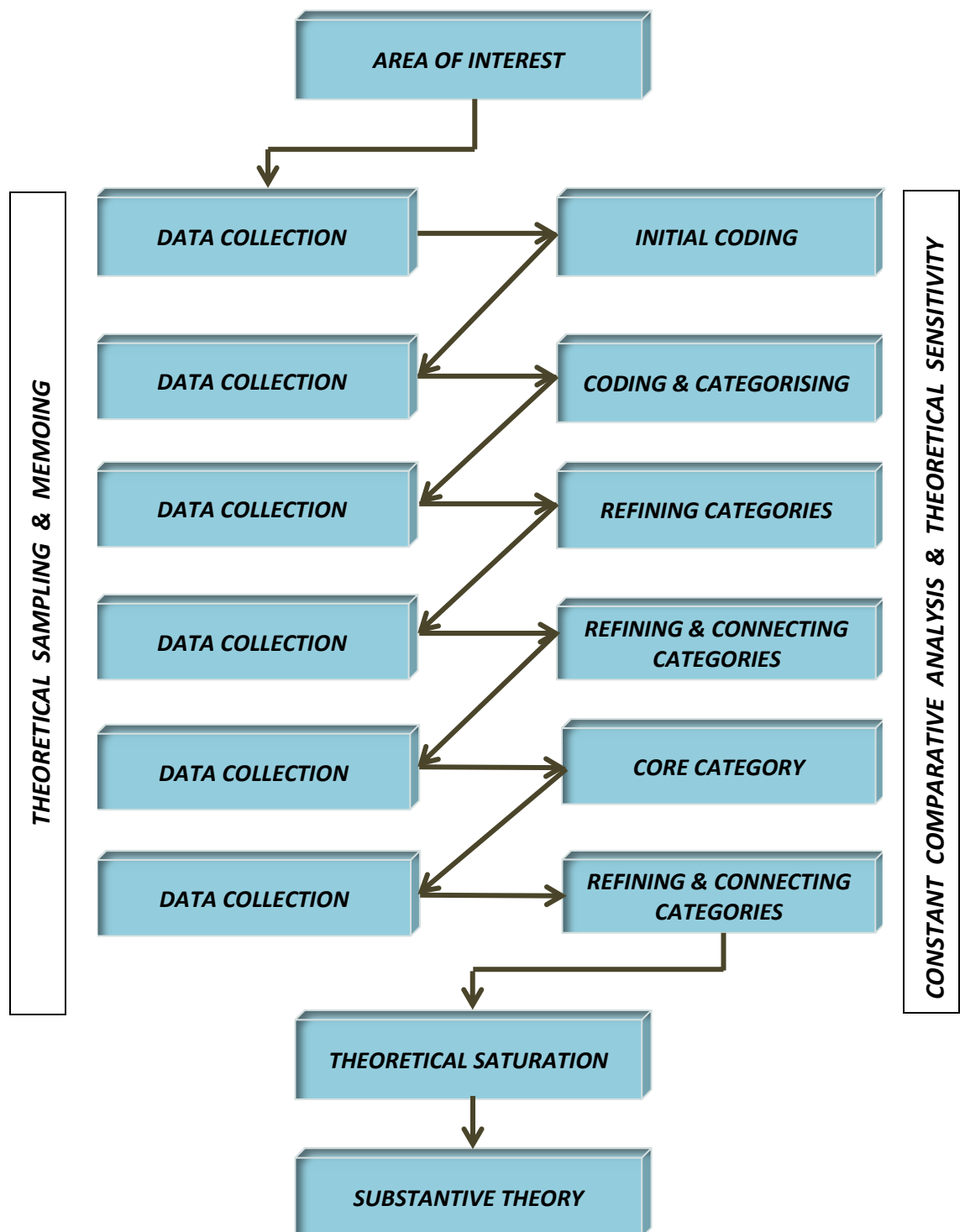


Figure 10: Process of data collection and analysis applied in this Grounded Theory research

Constant Comparative Analysis Method

The constant comparative method of data analysis is one of the main features of Grounded Theory methodology where data collection and analysis occur simultaneously commencing with initial data collection (Glaser & Straus 1967). This is when the analysis of data collected usually compels new data collection leading to further integration of categories to form a substantive theory (Birks & Mills 2011; Boeije 2002; Gibson & Hartman 2014; Glaser & Strauss 1967; Roberts & Taylor 2002; Straus & Corbin 2008; Urquhart 2013). This method of data analysis is an integral feature of Grounded Theory methodology and it is ‘consistently applied, despite the researcher’s philosophical or research orientation’ (Duchscher & Morgan 2004, p. 607).

According to Urquhart (2013, p. 17), the process of constant comparison ‘allows the meaning and construction of concepts to remain under review’. Therefore, Grounded Theory is ‘a dynamic relationship between sampling and analysis, which enables the researcher to check that emerging findings remain constant as further data is collected’ (Elliott & Lazenbatt 2005, p. 51).

This research aimed to generate a substantive theory grounded in the data being investigated in relation to the perspectives of NUMs and BNPCs regarding graduate RNs’ practice readiness within the Australian context. Therefore, the researcher used the constant comparative analysis method where she rigorously compared all newly collected data with data collected earlier (Gibson & Hartman 2014; Glaser & Strauss 1967).

This was done so as ‘to refine theoretically relevant categories’ (Polit & Hungler 1999, p. 698) until the conceptual emergence of the substantive theory ***Practice Readiness: A Nebulous Construct***. The process of data collection and analysis used within this Grounded Theory study is depicted in Figure 10. How the data were coded in this study is discussed next.

Coding

As in all Grounded Theory research, the coding of data started soon after the initial episode of data collection, as illustrated in Figure 10. According to Birks and Mills (2011, p. 10), Glaser and Straus (1967) did not provide a practical guide on the process of coding as they assumed that ‘the reader would know what this entailed’. Many years later in his book *Theoretical Sensitivity*, Glaser (1978) discusses conceptual abstraction and explains how it leads to the emergence of a substantive theory. However, Straus and Corbin (1990) in response to their students’ requests for a ‘how to’ manual of Grounded Theory, broke down the coding process into four steps – open, axial, selective and ‘coding for process’ (Urquhart 2013, p. 19). Glaser (1992) later disagreed with what he considered Strauss and Corbin’s modified version of Grounded Theory and asserted that the use of such coding process produces rigidity and leads to categories being forced upon data. He also criticised the deductive emphasis in Strauss and Corbin’s approach, ‘which requires the asking of numerous questions and speculation about what might be rather than what exists in the data’ (Heath & Cowley 2004, p. 144).

Glaser (2002a, p. 2) also argued that in classic Grounded Theory, participants have multiple perspectives and the researcher, through an inductive process, ‘comes along and raises these perspectives to the abstract level of conceptualization hoping to see the underlying or latent pattern, another perspective’. He adds that conceptualisation enables Grounded Theory to transcend ‘all descriptive methods and their associated problems, especially what is an accurate fact’ (Glaser 2002b, p. 24).

In this study, the researcher applied the three stages of coding techniques for data analysis based on Glaser’s classic Grounded Theory methodology (Glaser 1978, 1992, 1998), which underpins the theoretical paradigm of this research. These coding stages namely, open, selective and theoretical coding, are discussed next.

Open coding is the initial stage of constant comparative analysis where the researcher starts with an open mind (Glaser 1998). Open coding is described by Glaser (1978, p. 56) as ‘coding the data everyway [sic] possible’. This initial stage of coding involves comparing incidents and deriving codes of the data collected through ‘identifying important words, or groups of words, in the data and then labelling them accordingly’ (Birks & Mills 2011, p. 9). Urquhart (2013, p. 10) further explains that open coding is basically ‘going through the data, line by line or paragraph by paragraph, attaching codes to the data and very much staying open, seeing what the data might be telling you’.

According to Birks and Mills (2011, p. 93) ‘codes are a form of shorthand that researchers repeatedly use to identify conceptual recurrences and similarities in the patterns of participants’ experiences’. Glaser and Straus (1967, p.107) explain

that as open codes emerge, ‘the analyst will discover two kinds: those that he has constructed himself ... and those that have been abstracted from the language of the research situation’. Open codes might start by being descriptive codes, which simply describe the data and progress to analytic codes which analyse the data (Urquhart 2013). In Grounded Theory, many codes are formed from the words of participants in the substantive area (Glaser 1978) and they represent the ‘naming of an emergent social pattern grounded in research data’ (Glaser 2002b p. 24). When coding data, Glaser (1978) advocates the use of gerunds, which are ‘verbs used as nouns ... as they denote the action apparent in the data’ (Hoare, Mills & Francis 2012, p. 584).

During open coding, and guided by Glaser’s theoretical approach, the researcher broke down the data into incidents, made constant comparisons of incident to incident and always asked the question ‘what category or property of a category does this incident indicate?’ (Glaser 1992, p. 39). This is how the researcher developed the properties of the emergent categories in this study.

Figure 11 below presents a sample of how the researcher carried out open coding while going through the data line by line attaching codes to the data in an excerpt from an interview with a NUM. In this sample, the coded participant statements are underlined and the generated codes are colour coded to enhance readability.

Well you look at some of their prac and they went to a GP surgery, ...

valuing wide clinical exposure

They need to go and see that. They need to go see from the point of care,

valuing wide clinical exposure

from one end right to the other end. I truly believe that. ...

valuing wide clinical exposure

I disagree with the amount of time they're doing prac.

longer clinical exposure required

It needs to be a huge amount of time in prac you know. We're not giving them enough.

requiring longer clinical exposure

Make it a 4 year programme. It's a 4 year degree programme in the UK.

extend BN programme - requiring longer clinical exposure

That gives you an extra 12 months to do your prac you know - make it longer.

extend BN programme – requiring longer clinical exposure

You come straight out even as a grad nurse and we say they're protected and yes

expectation of support

they are protected in some way but they're not given a lighter case load. They're

grads are treated like other experienced RNs

given the same back-up, the same Enrolled Nurse, the same team as any other RN.

grads are treated like other experienced RNs

You can't say 'ohh we'll really give you the lightest patient load' it doesn't work

tension between expectation and reality

like that in the real world. They come out and they run the same as everybody else.

grads are treated like other experienced RNs / no clear role identity

There is actually nothing on their uniform to say I've been nursing 3 days, you've

grads are treated like other experienced RNs / no clear role identity

been nursing 30 years.

Figure 11: Sample open coding line by line

Open coding in the early stages of this study resulted in the development of an extensive range of codes. Figure 12 presents a sample of the initial codes that emerged from the data captured from participants in this study.

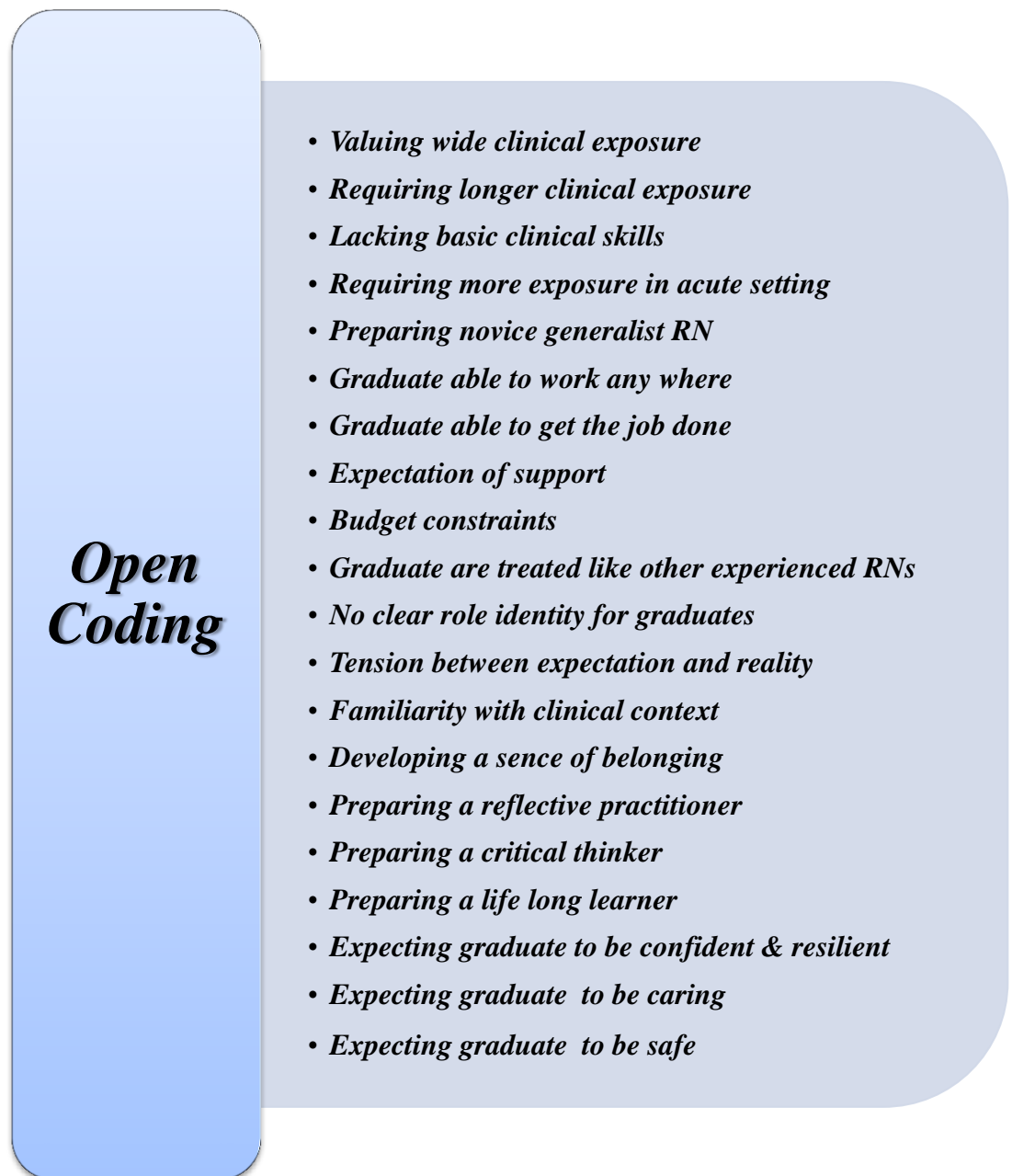


Figure 12: Initial codes emerged from open coding

The analytical process of open coding enabled the researcher to form the categories and to develop the properties of these categories (Glaser 1978, 1992). Birks and Mills (2011, p. 93) explain that ‘groups of codes representing a higher level concept form a category’. According to Glaser (1992, p. 39), ‘open coding comes to an end when it yields a core category’. In this study, the researcher ceased open coding and moved to selective coding, when the core category, namely, **Inhabiting Disparate Realities** emerged.

Selective coding in classic Grounded Theory is the second stage of coding and that is the point at which coding becomes limited to those categories that inform the core category (Glaser 1978, 1992). Urquhart (2013, p. 24) explains that:

... the point at which selective coding occurs is fairly obvious, as there are no new open codes suggesting themselves and definite themes are emerging. ... some grouping of categories can take place at this stage and this helps develop the abstraction of the theory.

According to Urquhart (2013, p. 24), this is where the Glaserian and Straussian strands of Grounded Theory methodology ‘sharply diverge’. Selecting a core category that is central to the data and that links with most other categories occurs at this stage of coding (Glaser 1978; Gibson & Hartman 2014; Urquhart 2013). Glaser (2005, p. 4) claims that researchers should deliberately look for a core category when coding the data but warns that ...

..., categories tend to emerge quickly, giving the appearance of finding core categories. But the analyst should be suspect of these as core. It takes time and much coding and analysis to verify a core category through saturation, relevance and workability.

The core category represents the main issue for the people involved, which ‘sums up, in a pattern of behaviour, the substance of what is going on in the data’

(Glaser 2005, p. 3). In this study, the core category **Inhabiting Disparate Realities** represents a pattern of behaviour that sums up what is going on in the data obtained from NUMs and BNPCs regarding their perspectives on graduate RN practice readiness.

The core category is selected ‘when the researcher can trace connections between a frequently occurring variable and all of the other categories, sub-categories and their properties and dimensions’ (Birks & Mills 2011, p. 101). The selection of a core category becomes a guide for theoretical sampling, which focuses on the collection of data that will theoretically saturate the core category and other related categories and sub-categories (Birks & Mills 2011; Glaser 1978; Urquhart 2013). Glaser warns novice researchers ‘the dictum is to write conceptually, by making theoretical statements about the relationship between concepts, rather than writing descriptive statements about people’ (2009, p. 7) and reminds them to ‘generate concepts that name patterns’ (2014, p. 11).

Selective coding in this study, led to the emergence of three categories and their associated sub-categories, which informed the core category **Inhabiting Disparate Realities**. Data excerpts that informed the emergence of these sub-categories, categories and core category will be offered in detail in *Chapter Four – Findings*.

Theoretical coding is the third and final stage of coding in classic Grounded Theory. This is the process of refining developed concepts and expanding ‘conceptual categories into a theoretical structure’ (Stern & Porr 2011, p. 70) leading to the emergence of a substantive theory (Gibson & Hartman 2014;

Urquhart 2013). Glaser (1998) warned that theoretical coding is one of the most challenging areas for grounded theorists, especially for novice researchers. According to Glaser (1978, p. 72),

... theoretical codes conceptualize how the substantive codes may relate to each other as hypotheses to be integrated into a theory. They, like substantive codes, are emergent; they weave the fractured story back together again.

Furthermore, Glaser (1992) reminds researchers to relentlessly keep asking the question ‘what is actually happening in the data?’ (p. 51) and once the initial analysis of the data is completed, they ‘must trust that emergence will occur and it does’ (p. 4). In classic Grounded Theory, theoretical codes must emerge from the data rather than being forced onto the data (Andrews et al. 2012; Glaser 1998). According to Glaser (1998, p. 163), ‘theoretical codes implicitly conceptualize how the substantive codes will relate to each other as interrelated multivariate hypotheses in accounting for resolving the main concern’.

Hernandez (2009) asserts that identifying theoretical codes is critical to the development of a substantive theory. She claims that ‘without theoretical codes, the substantive codes become mere themes to describe (rather than explain) a substantive area’, which is a characteristic of qualitative research methods not classic Grounded Theory (Hernandez 2009, p. 56). She explains that the ‘discovery of the ultimate theoretical code that integrates the substantive theory will probably occur during the selective coding phase, that is, after the core category has emerged’ (Hernandez 2009 p. 54).

In this research, the constant comparative method of data analysis ensured simultaneous coding and data collection. The researcher embarked on theoretical sampling by collecting data that led to theoretical saturation as a result of interviewing a total of sixteen participants. Theoretical coding enabled the researcher to refine the properties and relationships of the emergent categories and core category, which led to the conceptual emergence of the substantive theory ***Practice Readiness: A Nebulous Construct***. This conceptualisation was theoretically enhanced through applying the three basic tenets that underpin symbolic interactionism (Blumer 1969) as a practical theoretical framework to explain this substantive theory. Symbolic interactionism (Blumer 1969) and Charon's (2010) theorisation on how human beings see reality through perspectives were used in interpreting the findings of this study, which is elucidated further in *Chapter Five – Discussion*.

The next feature of Grounded Theory to be discussed is theoretical sampling. This discussion incorporates how theoretical sampling contributes to the development of categories leading to the conceptual emergence of a substantive theory.

Theoretical Sampling

Theoretical sampling has been identified by many researchers as a distinguishing and pivotal feature of Grounded Theory (Charmaz 2006; Elliott & Lazenbatt 2005; Gibson & Hartman 2014; Glaser 1998; Glaser & Straus 1967; Urquhart 2013). Glaser and Straus (1967, p. 45) defined theoretical sampling as:

... the process of data collection for generating theory whereby the analyst jointly collects, codes, and analyses his data and decides what data to collect next and where to find them, in order to develop his theory as it emerges. This process of data collection is controlled by the emerging theory, ... not based on a preconceived theoretical framework.

According to Urquhart (2013, p. 8), theoretical sampling means that ‘researchers analyse the data in the field and use the emerging concepts from that analysis to decide where to sample from next’. Charmaz and Bryant (2010, p. 292) explain that theoretical sampling requires ‘sampling for developing the properties of a tentative category, not for ensuring representation of a sample of people with a particular demographic characteristic’. The objective of theoretical sampling is to explore participants’ perspectives regarding some of the emerging categories in an attempt to further develop the properties of these categories (Andrews et al. 2012) and to develop a substantive theory emerging from the data being investigated (Glaser & Strauss 1967). Therefore, theoretical sampling ‘is a deductive process undertaken to focus the collection and analysis of data and verify the properties of categories’ (Andersen, Inoue & Walsh 2013, p. 4). Engaging in theoretical sampling enables researchers to add new participants or to ask earlier participants further questions to ‘find needed data to fill gaps and to saturate categories’ (Charmaz 2006, p. 103).

In this study, the researcher conceptualised a theoretical framework and used theoretical sampling of participants to gather data to fill the theoretical gaps. In order to develop and saturate the properties of emergent categories, the researcher explored participants’ views on multiple issues in relation to clinical and theoretical components of BN curricula, expectations of newly graduated RNs in the work place, implications of professional and contextual enculturation, and

economic considerations related to clinical placements of students and the support of novice graduates. A total of sixteen participants – seven NUMs and nine BNPCs were interviewed through initial purposeful and then theoretical sampling. This helped to develop the properties of the emerging categories and core category and enabled the conceptual emergence of the substantive theory ***Practice Readiness: A Nebulous Construct***. Theoretical sensitivity, as another feature of Grounded Theory research, and how it contributes to the conceptualisation of the substantive theory, is discussed in the following section.

Theoretical Sensitivity

According to Glaser and Strauss (1967), theoretical sensitivity reflects the researchers' level of insight into their area of research and their ability to make something of their insights. Insight is defined as 'the capacity to gain an accurate and deep understanding of someone or something' (Oxford Dictionary). Theoretical sensitivity is the 'ability of the researcher to think inductively and move from the particular (data) to the general or abstract' (Schreiber & Stern 2001, p. 60). It is the ability of the researcher to work with the data in a sensitive but theoretical way (Glaser 1978).

Birks and Mills (2011, p. 11) point out that theoretical sensitivity was first discussed by Glaser and Strauss (1967) as a two-part concept:

Firstly, a researcher's level of theoretical sensitivity is deeply personal; it reflects their level of insight into both themselves and the area that they are researching. Secondly, a researcher's level of theoretical sensitivity reflects their intellectual history, the type of theory that they have read, absorbed and now use in their everyday thought.

Strauss and Corbin (1998) define theoretical sensitivity as the ability to identify subtle cues in the data and abstract meaning. Glaser (1978) argues that embarking on a research project with minimal pre-conceived ideas is a preliminary step in achieving theoretical sensitivity. He adds that theoretical sensitivity guards researchers against potential bias from their personal beliefs and enables theory formation to emerge from the data rather than promoting researcher's preconceived ideas (Glaser 1998).

In this study, the researcher's prior experience and knowledge of the substantive area enabled her to 'recognise the nuances and understand the subtlety of what is being said by participants in the field and in the analysis of the data' (Walls, Parahoo & Fleming 2010, p. 11). This provided a source of theoretical sensitivity. Moreover, the researcher wrote copious memos throughout the research process and regularly referred to her supervisors to reflect on the data and emerging themes, to further enhance theoretical sensitivity. Enhancing the researcher's theoretical sensitivity facilitated the constant comparative method for data analysis. Considerations of sample size and theoretical saturation in Grounded Theory and their application in this study are now explored.

Sample Size and Theoretical Saturation

Decisions regarding sample size in qualitative research are different from those in quantitative studies' and take into consideration the expectations of the study (Burns & Grove 1999, p. 356). In Grounded Theory, as in other qualitative

research, the sample size is considered appropriate and data collection stops when data saturation occurs and no new concepts emerge (Charmaz 2006; Cleary, Horsfall & Hayter 2014; Gibson & Hartman 2014; Glaser & Strauss 1967; Liamputtong 2009; Marshall et al. 2013; Mason 2010; Stern & Porr 2011; Strauss & Corbin 2008; Urquhart 2013).

Furthermore, and as discussed earlier in this chapter, sampling techniques also differ in qualitative research, where participants are selected for their insight and experience related to the topic under study (Cleary, Horsfall & Hayter 2014). As qualitative research is concerned with meaning and does not intend to generalise findings, it therefore requires a smaller number of participants in comparison with quantitative research studies (Burns & Grove 1999; Polit & Beck 2012; Roberts & Taylor 2002). According to Burns and Grove (1999), it is not unusual to conduct a qualitative study of six to ten participants. Moreover, trustworthiness of the reporting is more important in Grounded Theory than the sample size or the number of data events (Bruce 2007). Glaser (1998, p. 144) warns that ...

Quite often researchers who are not doing grounded theory collect “tons” of data. They believe full descriptive coverage is their research goal. Also beginning grounded theorists who are not used to coding, analyzing, and theoretical sampling tend to collect too much data. They just collect since they do not avail themselves of delimiting aspects of grounded theory.

Clearly some researchers find this frustrating. ‘Although the idea of saturation is helpful at the conceptual level, it provides little practical guidance for estimating sample sizes for robust research prior to data collection’ (Guest, Bunce & Johnson 2006, p. 59).

To better understand the link between sample size and theoretical saturation in qualitative research, Mason (2010) reviewed five hundred and fifty PhD studies and determined the mean sample size to be thirty-one interviews. However, in a study involving sixty in-depth interviews, Guest, Bunce and Johnson (2006) documented the progression of theme identification in an effort to determine the number of interviews needed to achieve thematic saturation. They found that saturation was reached within the first twelve interviews and that some basic categories were formed as early as six interviews (Guest, Bunce & Johnson 2006).

According to Glaser and Strauss (1967, p. 61), theoretical saturation is achieved when no additional data are found and the researcher becomes ‘empirically confident that a category is saturated’. Charmaz (2006, p.113) concurs that ‘categories are saturated when gathering fresh data no longer sparks new theoretical insights, nor reveals new properties of these core theoretical categories’. However, Glaser (2001, p. 191) cautions researchers that:

Saturation is not seeing the same pattern over and over again. It is the conceptualization of comparisons of these incidents which yield different properties of the pattern, until no new properties of the pattern emerge. This yields the conceptual density that when integrated into hypotheses make up the body of the generated grounded theory with theoretical completeness.

In this study, the researcher was guided by Glaser’s (2001) perspective on theoretical saturation, which led to a total of sixteen participants – seven NUMs and nine BNPCs being interviewed. The process of memo writing and its contribution to the theoretical conceptualisation process of data analysis is discussed next.

Memo Writing

According to Glaser (1978, p. 83), ‘memos are the theorizing write-up of ideas about codes and their relationships as they strike the analyst while coding’. Duchscher and Morgan (2004, p. 609) add that ‘memoing is the theoretical writing-up of ideas, separate from the data, that focuses on relationships between codes and their properties as they become evident to the analyst’. In Grounded Theory, memo writing is an ongoing activity that continues throughout the different phases of the research project (Andersen, Inoue & Walsh 2013; Birks & Mills 2011; Charmaz 2006; Glaser 1978). According to Polit and Hungler (1999), the coding and analysis of data gathered is facilitated by the writing of memos, which are notes written by the researcher documenting his/her ideas, feelings, insights, themes and emerging concepts. Hunter et al. (2011, p. 7) add that memos should represent the ‘researcher’s thoughts, questions and observations ... [and] link coding and theory development’.

Glaser and Strauss (1967, p. 107) assert that in Grounded Theory, the researcher ‘should take as much time as necessary to reflect and carry his thinking to its most logical (grounded in the data, not speculative) conclusions’. Furthermore, Glaser (1978, p. 83) warns that ‘if the analyst skips this stage by going directly from coding to sorting or to writing – he is not doing grounded theory’.

Montgomery and Baily (2007) agree that ‘memos essentially reflect the researcher’s conceptual speculations’ (p. 71) but they conceded that ‘memoing is initially awkward’ (p. 69). On that point, Glaser (1998, p. 178) suggested that:

Memos are not to be submitted for performance evaluation. One block to memo freedom is that others or an advisor will see them and evaluate them, so they must be presented as “good” or “perfected”. Absolutely no! A memo is for moment capture. The goal is to capture meanings and ideas for one’s growing theory at the moment they occur, which is far away from ready to show to other.

In this study and throughout the research process, the researcher wrote numerous memos about the data that was being collected and the coding process. These memos provide an audit trail of the researcher’s analytic process and decision making throughout this study. Figure 13 below offers a sample theoretical memo written by the researcher in an effort to capture meanings and link coding to theory development.

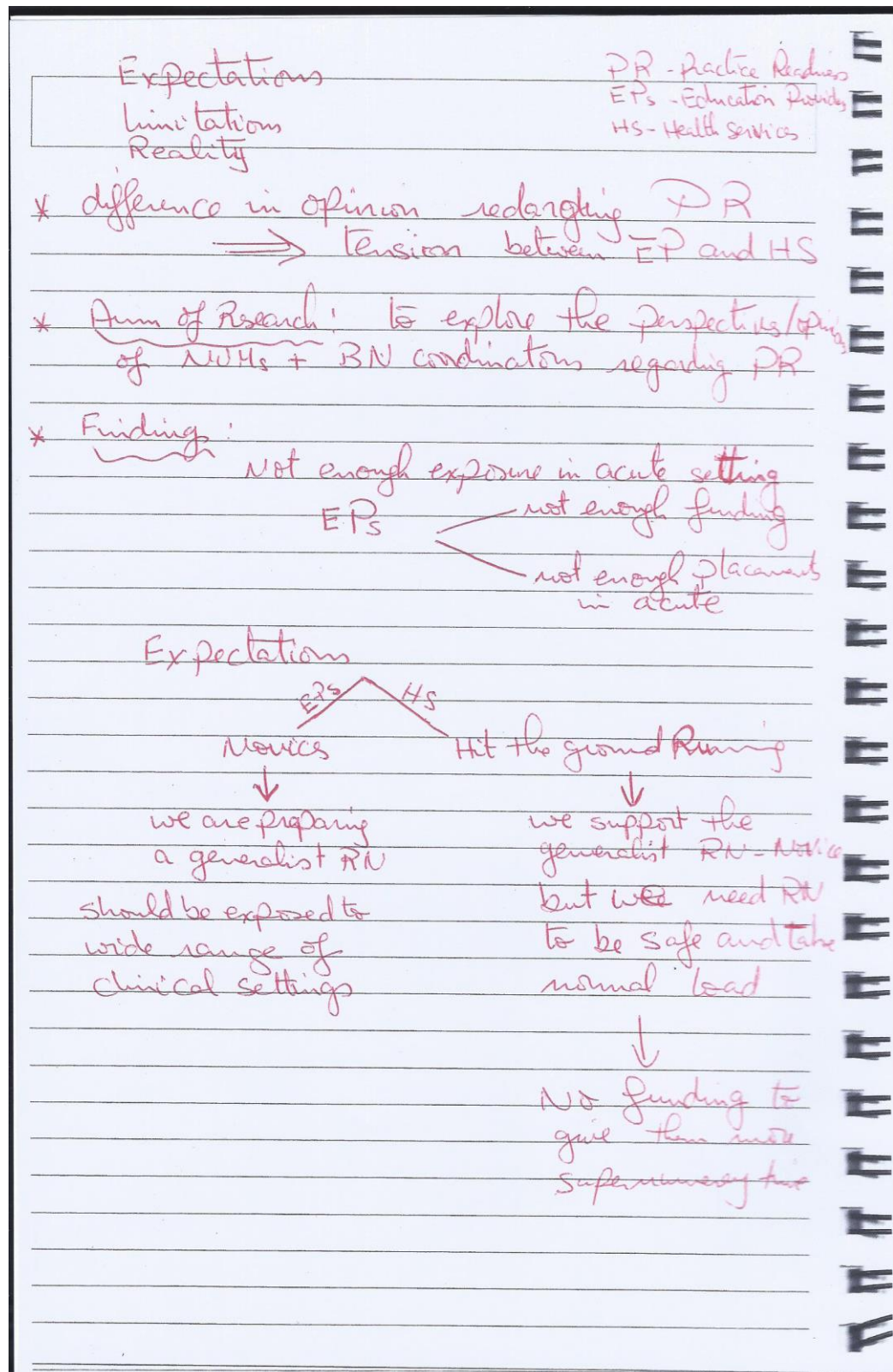


Figure 13: Sample theoretical memo

This completes the discussion on how data analysis, underpinned by the main features of classic Grounded Theory methodology, was implemented in this study. A brief discussion on how the data were managed now follows.

Computer Assisted Data Management

The computer software programme NVivo™ (version 9) was used to manage data in this study and to facilitate the process of data analysis and coding. Even though this software was used to electronically code the data, which facilitated the constant comparative analysis, the researcher still read and re-read all interview transcripts thoroughly in hard copy. The use of such computer software enabled the researcher to identify the number of sources to each code; to search and retrieve quotes from within the coded documents; and to refine the coding process. Figure 14 below presents an NVivo screen shot of the selective coding process in its early stages as related to the category **enculturation**.

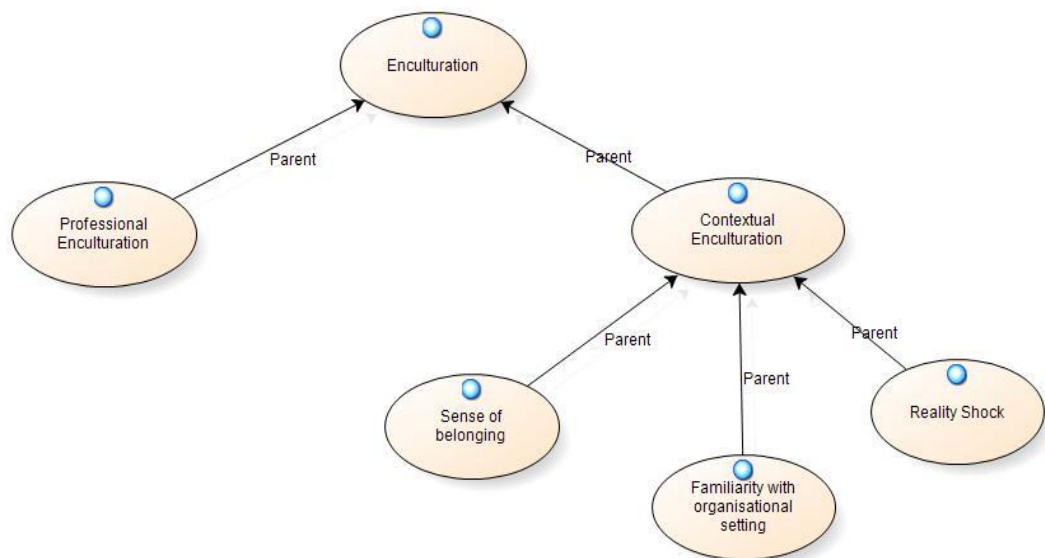


Figure 14: Sample NVivo screen shot

Criteria for Quality in Grounded Theory Research

According to Birks and Mills (2011, p. 33), there is ‘considerable debate surrounding how quality can and should be evaluated with respect to research undertaken within various paradigmatic frameworks’. In contrast to quantitative research, qualitative research values the researchers’ subjectivity and their ability to ‘remain self-aware, reflexive and self-monitoring in order to maintain the rigour and credibility of findings’ (Freshwater et al. 2010, p. 498). Bagnasco, Ghirotto and Sasso (2014) suggest that maintaining consistency between the research question and methodology is central to achieving quality in qualitative research. Given the multiple meanings and the degree of interpretation associated with qualitative content analysis, trustworthiness of findings in qualitative research is essential (Graneheim & Lundman 2004). Therefore, judgements regarding the quality of research are measured differently in qualitative and quantitative research.

In Grounded Theory research, concepts such as credibility and transferability replace rigour and validity (Elliott & Lazenbatt 2005; Freshwater et al. 2010). Moreover, Polit and Beck (2008, p. 536) assert that the use of terms such as rigor and validity when assessing the quality of qualitative research is a contentious issue among some researchers ‘because they are associated with the positivist paradigm and are seen as inappropriate goals for research conducted in the naturalistic or critical paradigms’.

Grbich (1999, p. 9) stated that ‘the postmodern rejection of the grand theory as a singular explanation of ‘reality’, in favour of multiple perspectives and the

development of small-scale contextual theoretical explanations, adds greater complexity to this debate'. As Freshwater et al. (2010, p. 502) point out, the aim of qualitative evidence 'is not to produce evidence that allows for generalisation ... but rather it seeks to 'open up' debate and discussion in order to inform thinking'. Moreover, Grounded Theory researchers view their theory as 'representing one of multiple, intangible realities about what may be happening regarding human action and interaction' (Schneider et al. 2003, p. 167).

Credibility

Credibility is an important consideration for qualitative researchers and it 'refers to confidence in the truth of the data and interpretations of them' (Polit & Beck 2012, p. 585). Establishing credibility of qualitative data is generally achieved through member checking (Cutcliffe 2005; Polit & Beck 2012). This is where 'researchers provide feedback to participants about emerging interpretations, and obtain participants' reactions' (Polit & Beck 2012, p. 591). However, member checking is redundant as a source of verification for conceptual analysis in Grounded Theory research. This is because the process of concurrent data collection and analysis supersedes the technique of member checking (Birks & Mills 2011; Charmaz 2006). After all, Glaser (2002b, p. 25) warned that:

Inviting participants to review the theory for whether or not it is their voice is wrong as a "check" or "test" on validity. They may or may not understand the theory, or even like the theory if they do understand it. ... GT is generated from much data, of which many participants may be empirically unaware. ... GT is not their voice: it is a generated abstraction from their doings and their meanings that are taken as data for the conceptual generation.

With regard to achieving credibility in Grounded Theory, Cooney (2011, p. 18) points out that some researchers focus on the process of how the study was carried out and others on the analytical practices applied and suggests that ‘process and product must both be considered when judging the credibility of a grounded theory study’.

For example, Glaser and Strauss (1967) and Elliott and Lazenbatt (2005) suggest that credibility of Grounded Theory research is achieved through engaging in research processes such as concurrent data collection and constant comparative analysis; theoretical sampling and the writing of memos. Hence, rationalising the selection of participants through the purposive and theoretical sampling is essential to the credibility of qualitative research (Bagnasco, Ghirotto & Sasso 2014; Cleary, Horsfall & Hayter 2014). Furthermore, Chiovitti and Piran (2003, p. 427), focus on the analytical practices applied by the researcher such as letting ‘participants guide the inquiry process’ as a measure to enhance the credibility of Grounded Theory research. According to Andersen, Inoue and Walsh (2013), theoretical sensitivity as described earlier in this chapter is another Grounded Theory research practice that guards against potential biases, which threaten the credibility of a research study.

Engaging in concurrent data collection and constant comparative analysis; theoretical sampling and the writing of memos enabled the researcher to engage in theoretical conceptualisation on the phenomenon of interest – the perspectives of NUMs and BNPCs regarding graduate RNs practice readiness – enabling whatever is theoretically relevant to emerge. To safeguard the credibility of this

study, the researcher focused on both processes and analytical practices as discussed above. Furthermore, the purposeful sampling of NUMs and BNPCs as participants who could add insights into the issue being investigated, also contributed to the credibility of this research.

Transferability

For qualitative research to be considered trustworthy and sound, transferability is an important consideration (Graneheim & Lundman 2004). Transferability refers to ‘the extent to which qualitative findings can be transferred to other settings or groups’ (Polit & Beck 2008, p. 768). According to Polit and Beck (2010, p. 1451), the ‘goal of most qualitative studies is not to generalize but rather to provide a rich, contextualized understanding of some aspect of human experience through the intensive study of particular cases’. These researchers add that it is up to the readers and consumers of research to ‘evaluate the extent to which the findings apply to new situations’ (Polit & Beck 2010, p. 1453). However, Denzin and Lincoln (2005) argue that it is also the responsibility of the researcher to provide a rich and thorough description of the research setting and processes so as to enable others to evaluate the applicability of the findings to other context, hence enhancing transferability. To facilitate transferability, Graneheim and Lundman (2004, p. 110) advocate that:

... it is valuable to give a clear and distinct description of culture and context, selection and characteristics of participants, data collection and process of analysis. A rich vigorous presentation of the findings together with appropriate quotations will also enhance transferability.

As such, the researcher in this study provided a thorough description of the research context, the processes that were applied and the substantive theory that had emerged to facilitate transferability.

Ethical Considerations

This research design has been cognisant of ethical considerations from its conception. Participant recruitment and data collection began only after ethical clearance was granted from the university Human Research Ethics Committee (HREC) (Approval number: H11/05-090 & HE12/356) (**Appendix 3**). Participants were requested to complete a consent form (**Appendix 2**) prior to partaking in this research once they had an opportunity to discuss the study with the researcher and have all their questions answered. In line with the National Health and Medical Research Council (NHMRC 2007) statement on ethical conduct in human research, the consent form was written in plain language and outlined the research title, aim, conditions and potential time requirements. The consent form also assured participants of their privacy and confidentiality and informed them of their right to refuse to participate, to refrain from answering questions and to withdraw from the study at any time without any fear of consequences. The researcher maintained integrity and merit, justice, beneficence and respect for all participants by adhering to the following ethical principles outlined in the national statement on ethical conduct in human research (NHMRC 2007):

- Data collection only commenced following ethics approval from the respective Human Research Ethics Committee.
- Participation was on an informed voluntary basis. Participants could refuse to participate, refrain from answering questions and/or withdraw from the study at any time without any fear of consequences.
- Participants' names and all other identifying characteristics were coded to ensure confidentiality and anonymity.
- Dissemination of information (thesis, conference presentations, seminars and journal articles) will not enable individual participants or their place of employment to be recognised.
- Participant confidentiality was maintained by ensuring that all research hardcopy data was stored in a locked filing cabinet in the researcher's office and digital data was stored on a password protected computer. All research data will be kept for a minimum period of five years after the final publication of the research project.

No participants indicated they were distressed as a result of their involvement in the study; no complaints or concerns were voiced regarding the study design or methods including data collection and all administrative ethics processes were adhered to throughout this study.

Chapter Summary

Chapter Three provided a detailed discussion of the underlying research paradigm and methodology for this research study. This discussion started by providing a justification for why a Grounded Theory approach was an ideal methodology for this research. The first reason was the desire of the researcher to explore a social phenomenon from the perspective of the people involved. Given the debate indicating a difference in opinion as to whether recently graduated RNs are in fact practice ready, the phenomenon of interest for this study is the perspectives of NUMs and BNPCs regarding graduate RNs practice readiness. The second reason was the paucity of research on this topic.

The theoretical paradigm that informed this study drew on Glaser's (1978; 1992; 1998) Grounded Theory approach. Congruent with this approach, the processes implemented by the researcher such as theoretical sampling; theoretical saturation; theoretical sensitivity; constant comparative analysis; open, selective and theoretical coding; and memoing were thoroughly deliberated in this chapter. Moreover, ethical considerations and elements of credibility and transferability related to this study were also discussed.

This research contributed to the conceptual emergence of the substantive theory ***Practice Readiness: A Nebulous Construct***. *Chapter Four* will now present the findings of this study and the conceptual emergence of the substantive theory.

CHAPTER FOUR

FINDINGS

Introduction

Chapter Three presented a comprehensive review of the research design and described the process of how the substantive theory, namely ***Practice Readiness: A Nebulous Construct*** emerged. To continue with the narrative that is this thesis, this chapter presents the findings of this study.

The chapter begins by presenting a discussion on how findings are positioned within Grounded Theory research. Following this, a snapshot of participant characteristics is revisited to rekindle insights into the purposive sample. Such participant characteristics are deliberately narrow in order to protect anonymity as discussed in *Chapter Three*. What then follows is an overview of the categories and sub-categories that informed the core category and led to the emergence of the substantive theory. The substantive theory emerged as a result of utilising the constant comparative method of data analysis, also described in *Chapter Three*. These findings are presented through the lens and words of the participants of this study. The approach used deliberately privileges participants' views and generates a theory that is useful, meaningful and relevant. The chapter concludes with a summary of key points. Figure 15 below explicates the configuration of the different concept levels including elements, sub-categories, categories and core category leading to the emergence of the substantive theory.

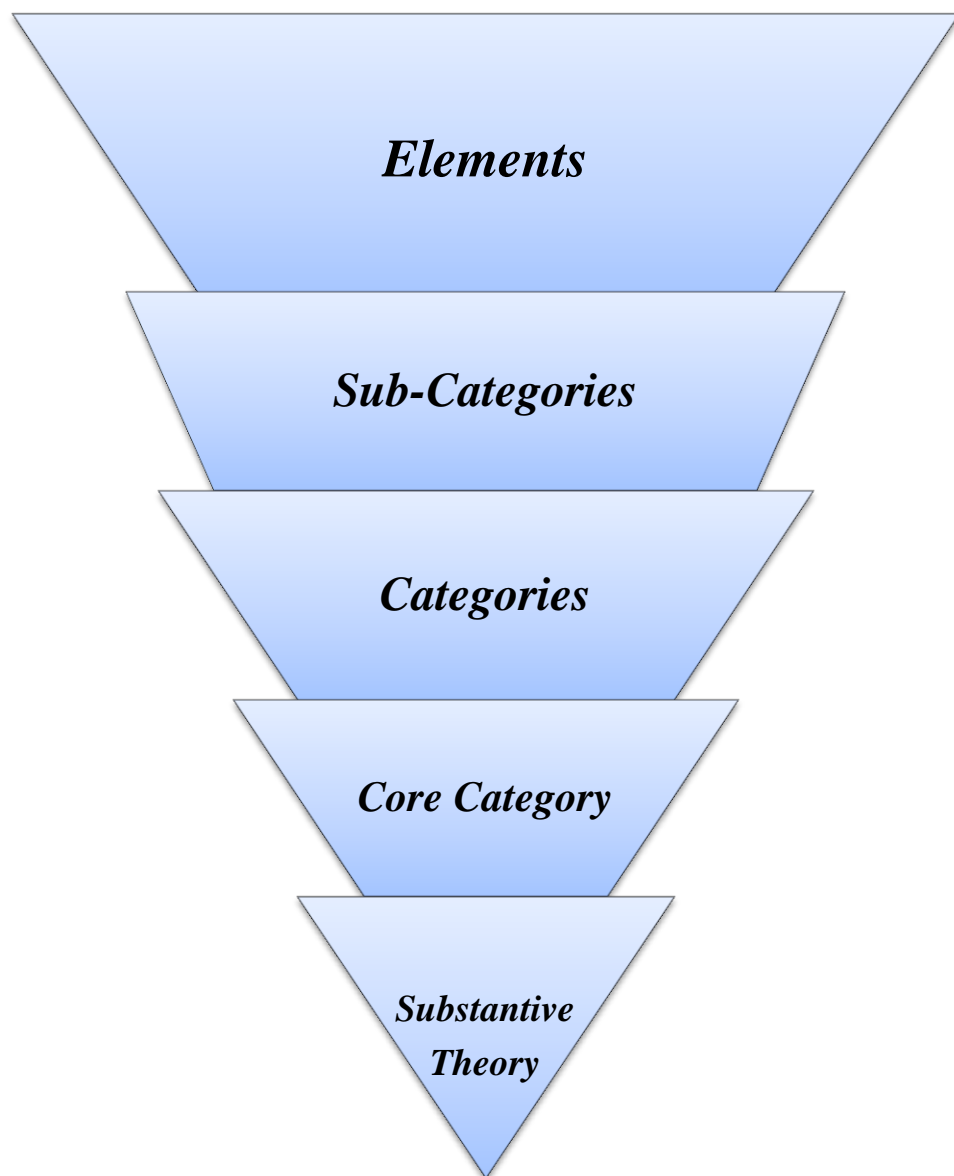


Figure 15: Concept levels leading to emergence of substantive theory

Research Findings in Grounded Theory

In contrast to the data-based results generated from quantitative research (Polit & Beck 2012), findings in qualitative studies are composed of researchers' interpretations of the data generated (Sandelowski & Leeman 2012). Indeed Sandelowski and Leeman (2012) remind us that findings in Grounded Theory studies are not simply about the number of codes generated but rather about the new conceptualisation derived from the analytic work of the researcher. Moreover, Glaser (2002a, p. 2) asserts that Grounded Theory is:

... a perspective based methodology and people's perspectives vary. ... then the GT researcher comes along and raises these perspectives to the abstract level of conceptualization hoping to see the underlying or latent pattern, another perspective.

This research, like other Grounded Theory research nests within the theoretical perspective of symbolic interactionism (Cutcliffe 2000; Derbyshire, Machin & Crozier 2015). In this study, the social phenomenon being investigated is the perspectives of NUMs and BNPCs regarding newly graduated RNs practice readiness in the Australian context.

As discussed in *Chapter Two*, the aim of this research was to explore the perspectives of NUMs and BNPCs regarding newly graduated RNs practice readiness and not necessarily to provide potential solutions to any perceived problems. However, giving voice to participants to discuss the issues they were concerned with meant that participants' perceived solutions and strategies for improving graduate RNs practice readiness were a feature of all interviews. The researcher's emphasis on presenting participants' narratives and privileging their voices, led to the inclusion of their perceived solutions and strategies in the data.

These data informed the conceptualisation and emergence of the substantive theory *Practice Readiness: A Nebulous Construct*.

The Substantive Theory

As described earlier, this research aimed to explore the perspectives of NUMs and BNPCs regarding newly graduated RN practice readiness. Utilising the constant comparative approach for data analysis led to the emergence of the substantive theory of *Practice Readiness: A Nebulous Construct*.

As suggested by the title of the substantive theory, the nature of practice readiness is nebulous, which denotes its vague and ill-defined nature. The following participant excerpts distinctly reflect such nebulous nature of newly graduated RN practice readiness:

P 7 (NUM): ... *the expectations we have of our new graduate population are too high.*

P 10 (BNPC): *Maybe our expectations are too high, maybe when we say we want them work ready we mean we want them work ready at the expert level and not the novice level.*

P 11 (BNPC): *It is about how might we choose to define graduate readiness. For the bulk of activity that goes on in those settings, they are probably quite capable.*

P 15 (BNPC): *It is about being critically minded, being able to discern change and things like that and I think from that perspective, yes, I think the graduates are quite ready but at the same time I have hesitancy about other aspects of being ready in terms of really managing time and really understanding the pressures of the clinical environment ... we can never account for the fear that is in graduates, you know the fear of actually being fully responsible and I struggle ... well how do you actually make someone ready for that?*

Factors that informed the theory *Practice Readiness: A Nebulous Construct* will now be explored in detail. This exploration will begin by discussing the core category, namely, **Inhabiting Disparate Realities**.

The Core Category

According to Birks and Mills (2011), a core category emerges when the researcher can trace connections between frequently occurring categories and sub-categories. Furthermore, the core category must be central to the data and must relate to most other categories (Glaser 1978; Gibson & Hartman 2014; Urquhart 2013). In this study, the core category, which explains the basic social process is **Inhabiting Disparate Realities**. **Inhabiting Disparate Realities** represents the social architecture regarding the worlds in which NUMS and BNPCs inhabit.

Inhabiting Disparate Realities

Inhabiting Disparate Realities fundamentally means that NUMs and BNPCs, as a result of varying **system drivers**, view graduate RN practice readiness through different lenses. Despite the fact that both participant cohorts acknowledged that **professional** and **contextual enculturation** contribute to graduate practice readiness, participants' opinions differed as to the focus and timing of when graduate RNs should attain **professional** and **contextual enculturation**. It is this divergence in opinion, as a result of varying **system drivers** that shaped participants' perspectives. As such, their priorities and expectations regarding graduate RN practice readiness were inevitably going to be different. Both cohorts

of participants recognise that newly graduated RNs are novice clinicians as evident in the following excerpts:

P 7 (NUM):... *you've [graduate RN] got the broad abilities as a registered nurse, you've got some foundational ingredients as a graduate nurse, ... there are some clinical skills that you will develop over time to reach a level of competence ... and confidence.*

P 9 (BNPC): ... *they [graduate RNs] would be a beginning level practitioner who could meet all the ANMC competency standards, but at a beginning level, so at a novice type of level.*

Based on the seminal work of Benner (1982, p. 403), novice clinicians are considered beginners who are unable to use discretionary judgment as they have 'no experience with the situations in which they are expected to perform tasks'.

Whilst recognising that newly graduated RNs are indeed novices, participants in this study acknowledged that graduates were also expected to **hit the floor running** as they commenced employment. **Inhabiting Disparate Realities** therefore, is a multifarious interplay of numerous features that in turn contribute to varied understandings of what it means to be practice ready. As such, the core category **Inhabiting Disparate Realities** is linked to three categories:

- **System drivers**
- **Enculturation**
- **Hit the floor running**

It is important to note that the categories that inform the substantive theory of *Practice Readiness: A Nebulous Construct*, are not mutually exclusive. Even though these categories are presented in the form of what might appear to be

discreet entities, often times the interplay between the different sub-categories of such categories means that there is going to be overlap.

The discussion that follows elucidates the different epistemological positions of participants, which informed the core category **Inhabiting Disparate Realities** and demonstrates its relationship to all other categories and sub-categories. The categories and sub-categories that emerged from the data and informed the conceptualisation of the substantive theory are discussed in greater depth in the following sections. The discussion commences with a description of the category **system drivers**.

System Drivers

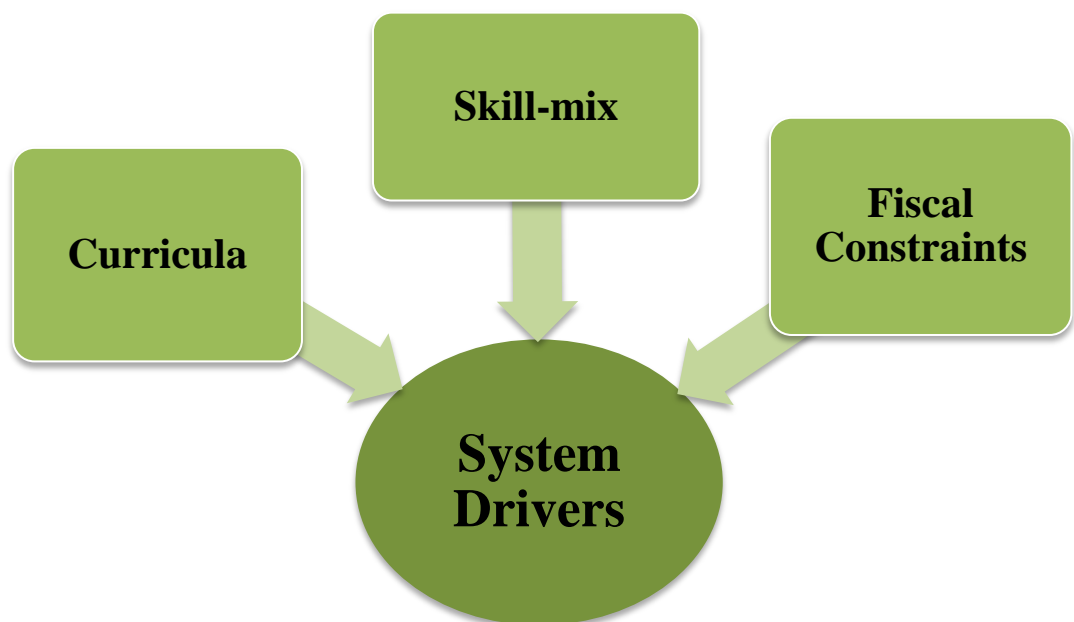


Figure 16: System Drivers

NUMs and BNPCs had different **system drivers** as depicted in Figure 16. In this study, **system drivers** relate to monetary and regulatory processes and standards that govern and drive both the practice and education sectors at macro (i.e. ANMAC/AHPRA) and micro (unit/ward) levels. As such, these **system drivers** inform peoples' decisions and drive their priorities and perspectives regarding graduate RN practice readiness in both sectors. In this study, **system drivers** are inclusive of **curricula**, **skill-mix** and **fiscal constraints**. Such **system drivers** led to participants having varying priorities, which influenced their expectations regarding newly graduated RN practice readiness.

The emerging sub-categories that informed **system drivers** are **curricula**, **skill-mix**, and **fiscal constraints**. These sub-categories are now discussed in greater detail. The discussion commences with the first sub-category, namely, **curricula**.

Curricula

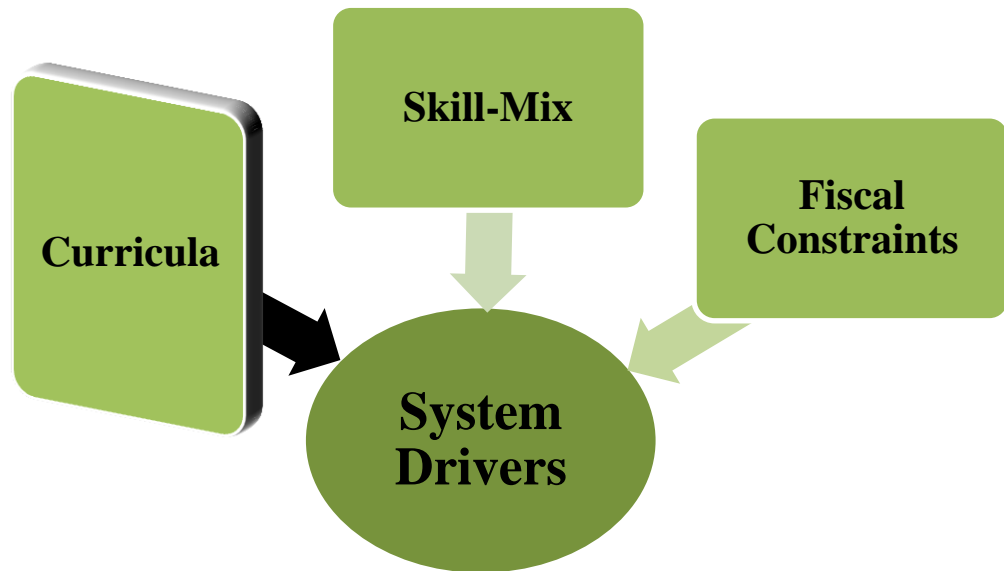


Figure 17: Curricula

As part of **system drivers**, certain features of the BN **curricula** (Figure 17) emerged consistently as a result of data analysis. Participants made reference to the notion of a curriculum that appears to be broad and inconsistent in nature, which they suggested, impacts on graduate RNs' preparation and clinical exposure. This in turn, was thought to have an influence on graduate RNs' practice readiness. The most significant of these features include: the broad nature of the curricula and their inconsistent theoretical and practical components; the perceived limited hours of clinical exposure; and the lack of consistency in student supervision and assessment of clinical competence.

The broad and inconsistent nature of the curricula

The comprehensive and broad nature of the BN curricula and the emphasis on preparing a generalist RN who is capable of working in any nursing context, featured prominently, particularly in BNPCs' reflections. The expectation that newly graduated RNs can aptly work in any practice setting in any jurisdiction, means that their educational preparation needs to be broad. This was not the reality for NUM participants from the acute care setting. The reality for these NUMs is not breadth. The reality for these NUMs is the specific contextual enculturation in the context of acute care setting. As a consequence of **system drivers**, NUM participants described the necessity of graduate RNs to be practice ready in the acute care setting. This is illustrated by one of the NUM's reflection:

P 1 (NUM): *... through no fault of their own, some [graduate RNs] were under prepared ... they had very limited placements within acute environments yet coming in to acute areas and simple things, simple skills, even the use of equipment, they would be terrified, they were very unaware of how to use them.*

The following participant reflections and insights reveal the extent of variation in the structure of each BN curriculum in Australia as a result of ANMAC (2012) accreditation requirements as well as industry engagement.

One BNPC describes the challenges faced by universities as they set out to prioritise the theoretical and clinical components to best inform their curricula:-

P 9 (BNPC): *... even compared to 20 years ago the acuity of the patient in the hospital is significantly different and ... it's really challenging for universities to produce a specialty type of nurse and what are the special skills that a nurse would require because I think ... if we went to every hospital and said "Tell us the type of course you want", every hospital would come up with something different, and at the end of the day there's*

probably a whole lot of core abilities that people need to have and then the specialist skills or knowledge can be learned when they graduate. ... we're really good at developing medical/surgical nurses; we're not so good at that whole comprehensive nursing, so we're starting to get better at considering that mental health nursing is really important, and that all nurses, generalist nurses need to have that knowledge as well, so I think we're getting much better, and not just mental health but primary health care, community care, those types of things are becoming more important in nursing courses rather than the skilled base type of learning.

Another BNPC offered a similar view, highlighting the same challenges:

P 13 (BNPC): As a course coordinator, I get constant pressure from lots of clinical areas, you know, "you need to be teaching the students this or that, or something else", and look, it would be lovely to teach everything that everybody wanted but we'd need a 10 year degree for that. So there is a limit and often when people say "oh, you need more aged care in your course", well ok, what are we going to take out of our course to put that in? ... because three years sounds like a long time, but to get somebody from absolute novice to a graduate level, you don't have a great deal of time.

The consultation and engagement process that universities undergo with the health industry as required by ANMAC (2012) accreditation standards is illustrated in the following excerpts:

P 9 (BNPC): ... we're kind of made to [consult with stakeholders] now. ... as part of that process we are asked by the accrediting body what consultation have we done ... and so we held public forums and said "What do you think of our nursing [programme]?" ... we have co-joined appointments between the health service and the university and then we have sessional staff or casual staff teaching into the programmes, we have people who come and write, you know, people in specialty areas ... that keeps it [curriculum] real.

P 11 (BNPC): ... our programme has been constructed using significant stakeholder consultation and senior health service managers and clinicians involved in the curriculum's construction so everything that's in it, everybody's broadly agreed that it's appropriate.

Even though universities and health services appear to engage in consultations and collaborations with regard to nursing education as required by the accreditation authority, one participant in this study suggested that each party has a different agenda:

P 12 (NUM): *I think the hospital has its own agenda, the university has its own agenda And they never seem to marry up and I think if everyone was on the same page and the universities were willing to put more resources; the hospital more resources ..., I think graduate nurses and their experience after is going to be a lot better for everybody, including the patients, if everyone got together, rather than have their own agenda.*

Despite a desire or requirement to engage, NUM and BNPC participants described what they perceived as a lack of meaningful collaboration and authentic partnership. Participants talked about collaboration but many felt it was not as meaningful as it could be. This was reflected in the following participants' excerpts:

P 1 (NUM): *Why isn't there more interaction between us?*

P 9 (BNPC): *... if health services actually work with the education facility, then they would understand ... how students are educated and how graduates are skilled.*

P 14 (BNPC): *I think there is better collaboration and integration than there used to be but I still think we've got a lot of room for improvement. Yeah, I think it would be nice to have a sort of national movement towards a lot more integration and working together.*

Furthermore, what is required within the BN curricula and the appropriateness of some clinical placements was considered by the following participant who suggested that:

P 5 (BNPC): *I don't know how we would address that dichotomy between what's required within our curriculum and where we want to expose our students ... you'd really need to relook at the way we divide our clinical calendars and the purpose of our clinical placements.*

The variation in clinical placements or workplace experience as it is sometimes referred to, and the notion of having to expose students to multiple clinical contexts as part of the BN programme emerged repeatedly within the data. This is in compliance with the *Registered Nurse Accreditation Standards* (ANMAC 2012, p. 13), which require the Australian BN curricula to provide students with clinical 'exposure to a variety of health-care settings'. This requirement was discussed by a participant who stated that:

P 15 (BNPC): *It's mandated from ANMAC that every student that undertakes a Bachelor of Nursing must do a clinical placement in those 5 areas and I guess it's just seeing that they have, they are rounded in their experiences because remembering that a Bachelor of Nursing is trying to prepare the student to be at a minimum standard to work in any area and so hence the requirement of aged care, medical, surgical, community and mental health.*

Several BNPCs discussed the difficulties in accessing quality placements for their students. This further highlights the extent of the variation in the structure of the BN curricula in Australia. Two BNPCs revealed that:

P 4 (BNPC): *... we expect students to have clinical placements across a variety of settings, and including public and private, ... sometimes that's not quite realistic.*

P 14 (BNPC): *It's getting harder to place students, we are having to look at all sorts of new ways to place them, new places to place them.*

Another BNPC discussed the varying clinical placement opportunities they offer students, highlighting the challenges faced by universities to simply getting students placed:

P 10 (BNPC): *... students will be going out on placements with slightly different focuses as well, and these are elective and they can choose which one that they'd like to go out on ... it will be ... rural and remote, as well as community, including mental health, so we're spreading the students across every sector in the healthcare sector that we can secure a placement ... we're including the private, the public, the community, rural and remote; every sector that we can find.*

The value of exposing students to a wide range of clinical settings was questioned and the risks associated with offering multiple short placements highlighted by the following participants:

P 11 (BNPC): *... it's ok to have exposure to a range of different things, and that's important, but it's also important to maximise learning so ... an individual student working in a particular clinical setting has time to ... have some degree of comfort, so in multiple placements in the short space of time, it takes them 3 days to settle and then 3 days to prepare to leave, and so they've only got 4 predicted days in the middle and what does that do for anybody. ... we are driven by health systems agreements for contracted places and how long places can be and how many universities they've got to serve and when they can happen, so we're kind of, the ideal world is not the world we live in.*

P 14 (BNPC): *It [two week placement] doesn't work well for assessment of the students, it just doesn't work well ... If we have a student who has certain challenges, learning needs ... it often doesn't even get picked up until later in the 2nd week and then they can start on the new placement and then again it's not even picked up and they've got through the whole 4 weeks without that really consistent assessment.*

One participant discussed the value of students returning to the same clinical environment in developing relationships with clinicians but also recognised the limitations of such approach in meeting ANMAC requirements:

P 15 (BNPC): ... *I think in an ideal world it would be nice for students to be able to return to the same place and start to develop relationships with the staff that are more meaningful so that they're not just a number, a bother "Oh here they are for another 2 weeks". But I also recognise that we can't meet those 5 areas ... aged care, medical, surgical, community and mental health ... I recognise that that's not practical.*

The variation in clinical hours offered by different Australian universities was evident by the reflections of some participants; once again highlighting the extent of the variation in the structure of the BN curricula.

Perceived limited hours of clinical exposure

Analysis of the data revealed that most participants thought that BN students ought to be offered more clinical hours for workplace experience than the current minimum of 800 hours as required by the *Registered Nurse Accreditation Standards* (ANMAC 2012). Participants also highlighted the associated challenges of accessing clinical placements.

One NUM acknowledged the difficulty in accessing clinical placements in general but still argued that more clinical exposure than what is already being offered is required for nursing students:

P 12 (NUM): *They [students] need more placement. I think there is not enough placements for them so if there's only three years, yes I know the university stuff [theory component] is extremely important, I don't take anything away from that, but I think the placements need to be longer.*

A similar view was offered by a different NUM who also suggested that students should have more clinical exposure:

P 2 (NUM): ... *they [students] should have a little bit more clinical so when they come to the areas they [graduates] are a little bit more confident in their own abilities.*

A BNPC also offered a similar view when they declared that:-

P 14 (BNPC): *I feel sad that our students don't have a whole lot more clinical placements, I actually think we are giving them a disservice ... students have limited clinical placement hours.*

The value of students undertaking more clinical placement hours than what is currently being offered was highlighted by participant 10.

P 10 (BNPC): ... *one of the things we did do was increase our number of hours that the students have exposure to a direct clinical environment. ... and we have done that, ... because we actually do believe that it will benefit the students by having a greater exposure to clinical areas.*

The following BNPC added their voice to the above argument and suggested that:-

P 13 (BNPC): *Ultimately working with real patients and real clinicians is what I believe students need.*

Given that most graduate RNs are employed in the acute hospital sector, several NUMs/participants emphasised the need to have more clinical exposure focused within the acute setting.

P 1 (NUM): *I felt that the guys [newly graduated RNs] were very very under prepared at times ... some had very limited placements within acute environments yet coming into acute areas and simple things, simple skills, even the use of equipment, they would be terrified, they were very unaware of how to use them.*

P 16 (NUM): *They [students] need more clinical time [in acute] ... if I look at myself [a student nine years ago], my placement with community, mental health, ICU and then emergency ... having not been a previous nurse, like an AIN or EN, I had never set foot on a ward before. So when I started working [as a graduate RN in an acute medical ward] I didn't even know how to give the pan hop, how to put a pan in the pan hop because I had never had to do that in ICU or the community.*

The same NUM questioned the value of offering students wide clinical exposure in community and mental health settings as is the case with most Australian BN programmes, if graduates have no intentions of working in those settings:

P 16 (NUM): *I just wonder though, how valuable the community or mental health placements are if people don't have that intention [to work in those settings].*

A NUM reflected on their experience with some graduate RNs and added that:

P 3 (NUM): *... the people who have experienced prac within the hospital environment and an acute environment tend to say "oh I'll go do this"; "oh I'll go do that"; "can I help you with this" rather than somebody who stands there and is waiting to be told what to do. ... It's when you walk on a ward and you do an assessment of a patient ... working with a planner. When somebody comes up and says "oh no I've not seen one of these [shift planners] before" your heart sinks because everybody uses planners. So you know they've not been in an environment that works in this way. ... You're having to start from scratch with some people [graduate RNs]. ... They [students] need the acute training.*

Not everyone agreed with the view that students should be offered more clinical exposure in acute settings.

P 4 (BNPC): *... acute nursing is only one type of nursing, and nursing is attractive because you can work in so many different sectors ... I believe it's a myth that you need to do your first year or two within an acute setting, I don't think you need to at all, if that's not the area of nursing you go into ... where that's not your desire ... like I was talking to somebody yesterday who wanted to go into mental health nursing and she thought she should go into work in acute ward for a couple of years first and I just wondered why and she said, 'so I can learn some better skills, some acute case skills'.*

Despite suggesting there was not a need for increased clinical exposure in the acute setting, the same participant thought that to be able to work independently in community settings in Australia, graduate RNs require some clinical exposure in the acute care setting first and suggested that:

P 4 (BNPC): *... maybe the other areas [outside acute setting] need to look at different ways of doing their graduate years, ... and I know it happens in a couple of places that the graduate in the community setting ... can spend three months back in the acute area just for that refreshment and just so they can recognise when somebody is acutely ill within a community setting.*

Another BNPC affirmed that most graduates are initially employed in acute setting and offered a rationale for why newly graduated RNs are not initially employed in community settings:

P 15 (BNPC): *... the majority [of graduate RNs] certainly go to acute, so they go to hospital settings, ... I don't think many go into community straight up and that's often because community won't accept new grads ... graduates don't go straight into community settings because they don't have the experience ... you need to have experience behind you. ... because it's usually such an autonomous role as well, even though they might be in large settings where they have support when they go back to base, but the community is autonomous and you are making decisions and judgements yourself when you're alone with your client.*

Suggestions that students just do not have access to sufficient clinical exposure were made by the following participants:

P 4 (BNPC): ... *they [students] haven't spent a long time in the clinical environment.*

P 14 (BNPC): *I think it would be better for students to have more time on clinical ... if I had the ideal world, I would have students doing three times more clinical.*

Participants identified the limited access to clinical placements to be a major challenge for universities:

P 9 (BNPC): *It's incredibly challenging now to actually get the number of students that you get ... on clinical placement in three years.*

P 10 (BNPC): *A limiting factor for us sometimes, we feel, is the limited number of placements.*

The value of offering BN students more clinical hours than the minimum of 800 hours was also discussed by the following BNPC:

P 13 (BNPC): *I would actually like to see that [clinical hours] pushed out towards 1000 clinical hours because I think ultimately that is the thing that prepares students best for their graduate year, exposure to the clinical environment.*

The same participant sounded confident in that:

P 13 (BNPC): ... *clinical practice is the absolute key to having students prepared.*

Quality versus quantity of clinical placement was a notion that was discussed by one participant. A BNPC questioned the value of offering more clinical hours and suggested that the quality of clinical placement is of greater significance to student learning:

P 11 (BNPC): ... *I don't know that just more opportunity to practice more is the thing that we need to do and I think there's work going on internationally about the quality and the calibre of clinical placements and what the quality of learning is that takes place and how we assure that quality. ... I think it's about what are we doing with the time we've got and how can we make that more effective. ... So I think it's not about amount of time, it's about quality and how we structure the learning.*

The notion of working as an assistant in nursing (AIN) to further develop students' fundamental clinical skills as an adjunct to clinical placement was discussed by a number of participants. The following was suggested ...

P 12 (NUM): *If they've had a job as an AIN in a nursing home during their training, or in a hospital as an AIN, they tend to come with a bit more understanding because especially in the nursing home, they have to do that basic sort of care, and you know it's all the hands on, bathing, showering, toileting, everything like that, so I think when they do finish their degree, they know they're coming into a hospital in an acute surgical unit, for instance, but they still have to do those sorts of duties as well, rather than having worked at McDonald's and think "Ok, we're going to the hospital now and we don't have to do any of that stuff we did in first year nursing training".*

Highlighting the value of working in aged care to further develop students' fundamental clinical skills as an adjunct to clinical placement was also discussed by participants.

P 10 (BNPC): ... *a lot of our students, of course go and pick up additional positions or work in aged care facilities to try and expose themselves and get the practice, but it's up to them to do, we encourage that, but of course that's an individual thing that people do or choose to do.*

Given the paucity of available and appropriate clinical placements, a BNPC suggested that more could be done in terms of simulation to better prepare students as an adjunct to clinical placements:

P 5 (BNPC): ... *I think we can do a lot with simulation and I don't think we're doing as much with simulation as we need to be doing.*

Similarly, another participant also explained how simulation could be more greatly utilised to better prepare students:

P 9 (BNPC): *When we work in our simulation labs here at the university, ... the students don't walk in there and learn a skill, the student walks in there and there's a mannequin or a volunteer patient in the bed and they have to...you know, they have to speak to them, they do the assessment and whatever the skill that they're learning will be assessed on is within that case study. So I think things like that make people more work ready because they're thinking from the very beginning, it's not just about learning to wash my hands, or not just about this thing, it's actually about this whole person.*

As an extension of the argument by some participants that more clinical exposure is warranted to enhance the work readiness of graduate RNs, the notion of having a four-year rather than a three-year BN programme was raised.

One NUM stated:

P 3 (NUM): ... *I disagree with the amount of time they're doing prac. It needs to be a huge amount of time in prac you know. We're not giving them enough. ... Make it a 4 year programme. It's a 4 year degree programme in the UK. That gives you an extra 12 months to do your prac.*

Several BNPCs voiced similar views in support of the four-year BN programme.

P 6 (BNPC): *Most undergraduate degrees are four years. Why nursing ever agreed to three years? ... it's throwing out the baby with the bath water because that fourth year really allowed consolidation. And basically now they've got it with the new grad programme, but it's not the same ... it's just basically the health service is too busy.*

P 14 (BNPC): ... *we always talk about wishing that the degree could be a 4 year degree.*

Another BNPC added:

P 10 (BNPC): *I've always said that we should have an internship year where the students actually get paid for that 4th year, but industry hasn't been supportive and the University, probably not so much from the perspective of the cost, that extra cost of the course not only to the University but also to the student. So I think...it's more about logistics as opposed to the pedagogy of what we think would be a better program.*

Participants compared the educational preparation of registered nurses with that of other healthcare professionals and suggested provisional registration after completion of the three-year programme. One NUM suggested that:

P 7 (NUM): *... like Pharmacy have ... when you finish your three years of pharmacy, they have a pre-registration program that basically involves clinical supervision. They then, at the end of that time, they're given basic provisional registration, or basically a level of registration, and they then are provided with...after that...say, a period of time would be for an example, as a nurse, the fourth year, provided then with full registration. I believe going from the system we currently have where it's three years, you complete that three years and then you're fully registered, no checks and balances apart from the audits and the expectations professionally we have, is not as good as it could be, and using the success of other health professional groups to guide conversations in our profession to lead ... to a period where tertiary studies and assessments are completed within three years and that fourth year, as it is for interns and pharmacist's currently, is used for...ah...supported learning, work practice and clinical supervision and assessment, against the core requirements, and then full registration provided.*

The same NUM also recommended that the support of graduates in clinical settings need to be formalised and warned of implications of failing to implement the above:

P 7 (NUM): *... those other disciplines, like pharmacy and the level of support provided for supervision, and interns, as I said, the expectations aren't as great in that first year out because of that provisional registration, and therefore it's very structured support*

that they get to attain full registration, but because we don't do it, ... we're actually saying to other disciplines, and to ourselves as a profession, that...you know...we are ok...they're [graduates] finishing three years and...you know...the only additional learning that will occur is at times poorly planned, depending on the local unit culture and manager or district culture and leadership, would influence, I guess, your experiential learning in that first 12 months after graduation. We run many risks, I think, as a profession by not formalising it better.

Student supervision and assessment of clinical competence

Another feature of the BN curricula that was raised by participants highlighting its complex and varying nature is the assessment process. Participants discussed the assessment process and the implications associated with the lack of consistency and standardisation in the assessment of clinical competence.

The challenges faced by clinicians who work with students in the clinical environment due to the lack of standardisation of curricula and the variations in clinical assessment processes across different universities were highlighted by the following participant:

P 7 (NUM): ... one thing that would assist ... I think the national curriculum ... and the national curriculum, hopefully then with some consistency of expectations of levels of achievement throughout a three year nursing programme, so therefore, what you achieve in the first practicum of level three, would be the same from university to university. At the moment we don't have that ... It is made more difficult ... by having variations in clinical assessments and ... clinicians often don't have the time to truly appreciate ... the nuances between different practicums.

The same NUM suggested that more assessment scrutiny is required to ensure students' clinical competence:

P 7 (NUM): ... the difficulty for staff, who basically work with these students as they come through with an oversight of a clinical facilitator, often the facilitator's assessment is based on what the staff have said. Equally, it's [student's performance] not looked at in detail, the staff say 'This student is fine', they [clinical facilitators] don't then stand around and do an assessment, they just sign it off as fine and they get involved with the students that the staff are saying 'Look I've got some concerns' and then they do more detailed work.

Another NUM voiced a concern regarding new graduates, who are still learning themselves, having to work with and subsequently assess nursing students while on clinical placement:

P 16 (NUM): ... when we have grads and have students ... so like, one of my grads who started a week or 2 weeks' ago has got an EN student with them today. ... we have less staff here so these grads who are learning themselves are then having to take on students quite early in the piece. ... we try to avoid that but sometimes it's just unavoidable.

The inconsistency of the assessment process in the clinical environment was identified by a different participant who suggested that sometimes assessors fail to fail students who are not clinically competent:

P 12 (NUM): ... a lot of the people do their placement as a student nurse and don't actually become competent at specific things but get passed for that placement, and maybe ... if they don't become competent at certain skills they have to repeat them, ... or not go up to the second year until they have actually achieved specific things, ... some people are coming out as a graduate nurse and it's frustrating for me being in the profession to know that people don't even know how to use the manual blood pressure pump because they're always using the electronic one, so, saying that you're competent because you're marked competent once in a skills laboratory, does not mean you're competent at taking a blood pressure manually if you're not keeping up with those skills.

The value of standardising assessment processes was also discussed by several participants:

P 11 (BNPC): *... the clinicians ... want a single competency assessment framework, ... it eases the documentation and paper work, ... the confusion, that creates because one minute you've got a student from [a university], who use this particular package, and then the next day or the next week, you've got another student from a different place with a different package and you've got to retrain your thinking and then two weeks later you're back to a different student, so part of the consistency is that you don't have to keep flipping your mind, it's just ok, the students at level at a 3rd year, these are the things they need to do in this period of practice so that's much easier and clearer and ready to get that round in your head.*

P 15 (BNPC): *... just dealing with the assessments for students, if there was more consistency in that, I think it would make a difference to practicing nurses and ... therefore influence the experience of the students because if the nurses are confident "Oh, yeah, okay because you're a 1st year we are assessing for this", if they are confident in that then that automatically feeds into the students because they don't feel like they're a burden.*

The significance associated with the assessment of students' clinical competence was acknowledged by the following participant who argued that support and training for clinical assessors is warranted:

P 12 (NUM): *There has to be some training for the assessors, for the clinical facilitators so that they're not just passing everybody because they're getting 90% right, you know, they need to get, really, everything correct before progressing on.*

Similarly, a BNPC explained the process of preparing the preceptors who work with students in their final clinical placements:

P 9 (BNPC): *... the final clinical placement that our students do for six weeks is a placement where they have a preceptor ... and they work that person's roster for the six*

weeks, and so when we talk to the preceptors we say to them that by the end of the third or fourth week you should actually stand back and watch them, ... the person [student] shouldn't be following, you should just be walking around behind them and checking ... by the end of the six weeks, the students would be at a beginning RN level and managing whatever the patient load is ... so I think that can help towards having students work ready.

Highlighting the inconsistent and busy nature of the clinical environment, a BNPC acknowledged the challenges faced by clinicians when engaging in teaching and assessing students in the clinical environment:

P 6 (BNPC): I think the buddy nurses sometimes get used to having the student as a partner working alongside and they form a really solid collegiate relationship, but it's not extending the student, and ... whether it's the assertiveness of the facilitator to sort of say to the buddy, 'Remember this is going to be your colleague very shortly', you know, and it's that little constant reminder ... to the RN's because they get busy and they're doing things, and they could manage the patients very quickly, whereas to give the student their patient load and stand back, it's hard and it can be very frustrating.

Another BNPC voiced a similar view and discussed the impact of the casualisation of the workforce on student learning and assessment:

P 6 (BNPC): ... we've got casualisation of the workforce, you know the impact of that is significant on student learning. If you think back five years ago, if a student was on a clinical placement, we could guarantee that they would have the one Preceptor, you know, and they would have some really solid learning, which now they may not have.

The difficult role of preceptors was recognised by the following participant who also acknowledged that in their view, the stable workforce in the health service in which they worked, contributed to positive student learning in the clinical environment:

P 8 (NUM): *We've tried to address the issue of how to reward the preceptors, because it's tough going ... the staff really engage with their students or their grads, so we're really lucky, and as I said we've got stable staff and it makes such a huge difference.*

The above reflections and discourse by participants highlighted the broad and inconsistent nature of the BN curricula and their clinical component in Australia. The most significant of these emergent features include: the inconsistent and broad nature of the curricula; variations in context and hours of clinical exposure; and the lack of consistency in assessment of clinical competence. Participants believed that such inconsistencies and variation of curricula impact on graduate RNs' educational preparation and clinical exposure.

Despite the fact that this research did not set out to explore solutions, participants asserted their opinions and persisted in offering their perceived strategies and recommendations as related to enhancing graduate RNs practice readiness. As such, the researcher had to give voice to participants' recommendations regarding strategies such as simulation, working in aged care; and working as an AIN, to further develop students' fundamental clinical skills as an adjunct to clinical placement. Accordingly, the broad and inconsistent nature of the BN curricula and their clinical component in Australia as a **system driver**, were thought to have an influence on the perspectives of NUMs and BNPCs regarding graduate RN practice readiness.

This concludes the discussion on the sub-category **curricula**, which informed the category **system drivers**. **Skill-mix**, the second sub-category that informs **system drivers** is now considered and illustrated in Figure 18.

Skill-Mix

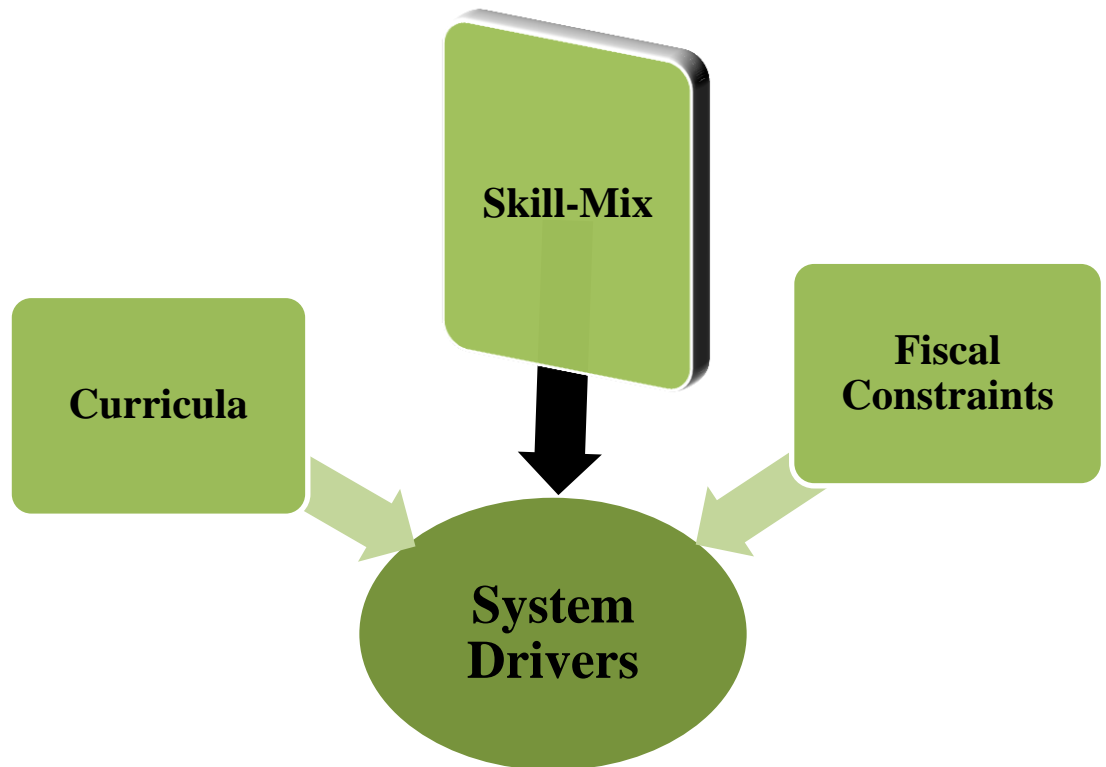


Figure 18: Skill-mix

In this study, rostering strategies and challenges related to maintaining safe **skill-mix** levels were discussed by both NUMs and BNPCs. The following excerpt explains the rostering approach used to enable a novice graduate RN to work closely with a more experienced clinician. This rostering arrangement is undertaken in an attempt to ensure the safe provision of patient care:

P 7 (NUM): ... you wouldn't basically have an allocation model where its 'here's your allocated patients, off you go and here's the closest nurse to you'. We work in a team model of care where you partner or buddy up the newly graduated registered nurse with a more experienced nurse, and they then care for the patient's in across the ward...for us...across eight patients. That's an essential part, I guess, of how we manage it, but the reason we probably do that is because graduate nurses ... they need to be guided ... You [graduate RN] need to be working alongside and have peer review undertaken by a more

experienced nurse, as they do in the other professional groups, early in your career, and the model of 'here's your group of patients'...whatever the ratio, is not a safe way of operating, because it lacks...and if that makes sense...peer review.

This participant also suggested a rostering approach to enable a positive learning environment for nursing students and graduates as well as to ensure the safe provision of patient care:

P 7 (NUM): *... there are simple things you can do that obviously make the transition from a poor learning environment to a good learning environment, ... it's about utilising all members of the health care team ... as potential teachers or supervisors of practice.*

Similarly another NUM offered the following insight, highlighting the value of having stable staffing levels when it comes to supporting graduate RNs in the clinical environment:

P 8 (NUM): *... we don't have as high a turnover of our own staff, so we have fairly stable staffing levels, ... because of the fact that you have got regular staff so you haven't got them [graduate RNs] working with agencies [agency nurses] ... we can pick up those who are struggling and give them extra staff development input or whatever else is required.*

The same participant highlighted the significance of supporting graduate RNs in the clinical environment and linked the notion of graduate support to workforce retention:

P 8 (NUM): *I'm accessible to them any time ... our responsibility is to support grads so that they stay in the profession. I need somebody to look after me.*

A rostering strategy was offered by one participant who aimed to ensure graduates were well supported to provide safe patient care:

P 2 (NUM): *... if they are having troubles I'll give them more day shifts and afternoon shifts when they'll be a little bit more supported ... they are fairly well supported here and they do have a person who they can go to throughout their time while they are here and who is their contact person on the ward.*

One BNPC reflected on the challenges associated with staffing and skill mix and acknowledged NUMs efforts in ensuring that graduate RNs are rostered appropriately:

P 10 (BNPC): *... as a NUM you don't allocate the severely complex patient to that nurse [graduate], you give them the patients that they can manage, but unfortunately ... that's not always, can't always happen because you have a cohort of patients that need...you've only got x number of nurses to cover the floor.*

The same participant expressed concern that graduate RNs sometimes find themselves in difficult situations without the necessary support and suggested:

P 10 (BNPC): *... the skill mix isn't perfect but occasionally we all know it does happen, nurses [graduates] are put in positions where it's not perfect for them, that they have to step up to a role with maybe not as much support as they would like.*

The following quote supports the above argument in that sometimes, graduate RNs find themselves in difficult situations without the necessary support regardless of the good intentions of NUMs. Here, a NUM gave an example of an incident related to a fairly new graduate RN who compromised patient safety by agreeing to work with two enrolled nurses (EN) as the delegating RN:

P 8 (NUM): ... one day somebody had to go home sick and one of these grads was fairly new and the coordinator didn't do a very good allocation ... and she put this particular new grad with an EN and an agency EN. Under scope of nursing practice, she was responsible for these 11 patients, and I sort of didn't realise initially that that was happening so ... I said to her 'I really appreciate that you were able to do that ... but at the end of the day, you don't have to do that, as a brand new grad, and under your scope of nursing practice, you are actually allowed to say: I don't know that this is particularly safe'.

Several participants acknowledged the challenges encountered by NUMs when trying to maintain appropriate skill-mix levels. A BNPC expressed their understanding of such staffing challenges associated with employing and supporting graduate RNs:

P 13 (BNPC): Sometimes you'll get a ward that has got a real lack of experienced staff so you've basically got very junior staff, not graduates, but junior staff supporting graduates, which can lead to absolute disaster for a nurse unit manager, so I can understand from their [NUMs] point of view that graduates do take a lot of support.

Another participant highlighted the tension between the need for NUMs to maintain a safe skill-mix on one hand and to manage within the fiscal constraints on another. This was all done while also trying to support novice clinicians:

P 11 (BNPC): ... If you don't give somebody a full load of work, then it means that somebody else has got to carry it, so there is a tension there with an economic argument and a philosophical argument ... And I think that some people [NUMs] have got that clear in their heads and they manage it well, others less so. ... there is a tension in the system about how people do that.

One NUM reflected on the challenges they face with regard to the limitations of rostering novice graduates and having to maintain patient safety as well as equity and fairness in workload among staff:

P 3 (NUM): ... *they're not given a lighter case load. They're given the same back-up, the same Enrolled Nurse, the same team as any other RN. You can't say 'oh we'll really give you the lightest' it doesn't work like that in the real world. They come out and they run the same as everybody else.*

The discourse above highlights the rostering strategies and challenges related to maintaining safe **skill-mix** levels as raised by participants in this study. NUMs discussed the challenges that confront them as they aim to be equitable and fair to all clinicians including the newly graduated RNs, while keeping a focus on patient safety and fiscal constraints. Even though BNPCs recognise such challenges and appear to be empathetic to the predicament of NUMs, they still expect graduates to be supported after employment. Accordingly, such rostering strategies and challenges related to maintaining safe **skill-mix** levels as a sub-category of **system drivers** have an impact on NUMs' and BNPCs' perceptions regarding graduate RNs' practice readiness.

This concludes the discussion on the emerging sub-category **skill-mix**, which informed the category **system drivers**. The third and last sub-category that informs **system drivers**, namely, **fiscal constraints** is now considered.

Fiscal Constraints

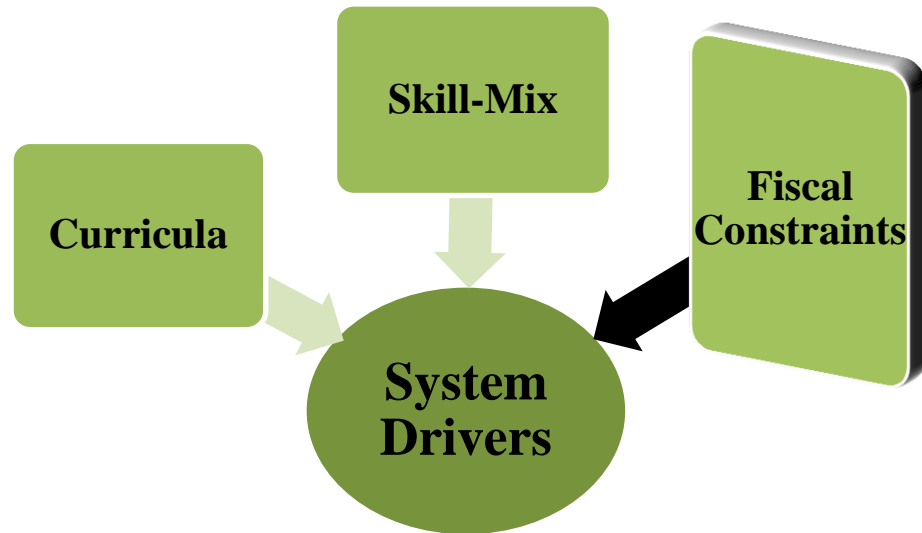


Figure 19: Fiscal Constraints

The sub-category **fiscal constraints** (Figure 19) emerged consistently as a result of data analysis. NUMs discussed the financial cost associated with providing additional support and supernumerary time for graduate RNs while BNPCs discussed the financial impact related to providing students with additional placement hours. Furthermore, the economic consideration associated with student employment within health services was also raised by participants. It was suggested that student employment could be a cost effective strategy for the upskilling of the nursing workforce while offering students greater opportunity for clinical exposure. Relevant quotes from participants are presented below to illustrate the emergence of **fiscal constraints** as a sub-category that informed the category **system drivers**.

NUMs are generally expected to manage their stringent ward budgets in a cost effective manner while maintaining a focus on patient safety. The following quote explains how one of the NUMs rationalised the benefits of the extra cost incurred by providing an additional period of induction for graduate RNs:

P 1 (NUM): Give me the 3 extra days induction with them [newly graduated RNs] and I'll give you 3 less sick days, in fact I'll give more than 3 days you can guarantee that. ... I guess, financially the fact is that there is going to be an upset – we obviously did have extra costs ... but as I say, when we looked at it that was offset by the amount of time we saved in sick leave.

The following NUMs illustrate the difficulty in balancing a stringent ward budget while offering a graduate RN additional support and supernumerary time:

P 3 (NUM): When they [newly graduated RNs] need extra support, they feel really bad. I look at them and go oooohh – you're gonna have to be supernumerary and how much is that gonna cost me? So you look at how much it's gonna impact on the ward as well.

P 16 (NUM): ... the grads have a day with the [educator] sometimes once a month, sometimes once every second month where they get to have a day with the [educator] ... over the month she might have seen some things that they need help with ... I think they find that really useful. Do I have it in my budget? No. ... All supernumerary days and these [education] days ..., anything like that is all considered over budget.

A BNPC expressed an understanding of NUMs concerns in terms of trying to balance the financial constraints and staffing challenges associated with employing newly graduated RNs, when saying:

P 13 (BNPC): *I know from my nurse unit manager, she often says to me "oh, such-and-such was a really good student, I'd love to have that person back as a graduate, but I just know that we can't support them", so there is that desire to want to support, but just because of budget cuts ... so I can understand from their [NUMs] point of view that graduates do take a lot of support and if you're looking at your budget, if you get a graduate who is a little bit slower, and requires more supernumerary time, you know, that's a big impact on your budget. I know of graduates who have required doubling times for 3 and 4 months; that must have a huge impact on a NUM's staffing budget to have it, you know, paying a registered nurse who actually isn't taking a patient load so I can completely understand where they're coming from.*

A similar view was expressed by another BNPC:

P 14 (BNPC): *I know what it's like, the burden of having staff who are not independent and they [NUMs] are getting staff [new graduates] that they are paying for out of their budget so they are supposed to be performing and these poor people can't, you know, they just don't have enough knowledge and so I don't blame the Nurse Unit Managers for having those complaints and ... I understand their frustration totally.*

The following quote represents the majority of views of BNPCs who disclosed discontent in relation to the financial burden universities have to bear as part of the provision of clinical placements. The following participant argued that the cost of clinical placements should be mutually incurred by both universities and health services to enhance the preparation of graduates:

P 4 (BNPC): *I do hear of the concern that our students aren't work ready, our graduates, sorry, aren't work ready, I hear that. ... we can't financially afford to run a programme that makes work ready students if you're [health services] charging us so much, ... [health services] need to provide a lot more support and lower expectations of graduates because of the lack of clinical placements.*

To the same point, another BNPC talked about the lack of resources and argued that preparing graduates should be a shared responsibility between the practice and education sectors:

P 14 (BNPC): *I actually don't think that the universities are able to get them ready for practice, I think our clinical partners are the integral people that actually get these students ready for practice ... we do as well as we can with the resources that we have.*

The financial implications related to the additional expense incurred by a university for offering students more clinical placement hours was highlighted by one participant while simultaneously acknowledging the value of increasing clinical exposure for students:

P 10 (BNPC): *... one of the things we did do was increase our number of hours that the students have exposure to a direct clinical environment. ... and we have done that, even though it is at great expense for our school, because we actually do believe that it will benefit the students by having a greater exposure to clinical areas.*

Another participant also acknowledged the value of increasing clinical exposure for students, while highlighting the financial cost to universities for providing students with additional exposure to the accreditation minimum of 800 hours:

P 13 (BNPC): *I get quite upset ... when I hear of courses wanting to drop their hours to the absolute accreditation minimum of 800 hours ... and I would actually like to see courses increase clinical hours rather than reduce them and I know that there are financial impacts around that ... but ultimately working with real patients and real clinicians is what I believe students need.*

As stated earlier, this research did not set out to explore strategies for enhancing graduate RNs practice readiness. However, the fact that participants continually

raised such strategies meant that they were such an imperative for them. As such, employing students was recommended as a cost effective strategy for health services to up-skill their nursing workforce while offering students with better opportunities for clinical exposure. The following participant illustrated this by saying:

P 6 (BNPC): ... it [student employment model] takes away that AIN role and you can actually cut down on your ENs because at the end of second year the undergraduate student has all the RN skills. So you're actually getting an up-skilling of your workforce for probably less money than a EEN. So there are those sort of economic considerations.

The above participants' quotes and reflections illustrate the emergence of the sub-category **fiscal constraints** from the data. NUMs discussed the financial cost associated with providing additional support and education for graduate RNs after employment. BNPCs on the other hand discussed the financial impact related to providing students with additional placement hours and in addition to the accreditation minimum of 800 hours to enhance their clinical exposure to the acute care setting. Aiming to offer solutions, some participants referred to the economic consideration associated with employing students within health services which is perceived to provide them with additional clinical exposure as well as financial support. Accordingly, such discussion by participants on **fiscal constraints** as a sub-category of **system drivers** would have an impact on NUMs' and BNPCs' perceptions regarding graduate RNs' practice readiness.

This concludes the discussion on the three emerging sub-categories, which informed the category **system drivers**, namely, **curricula**, **skill-mix**, and **fiscal constraints**. Relevant quotes from participants are now presented to discuss the

second category, namely **enculturation**. This is presented diagrammatically in Figure 20 below.

Enculturation

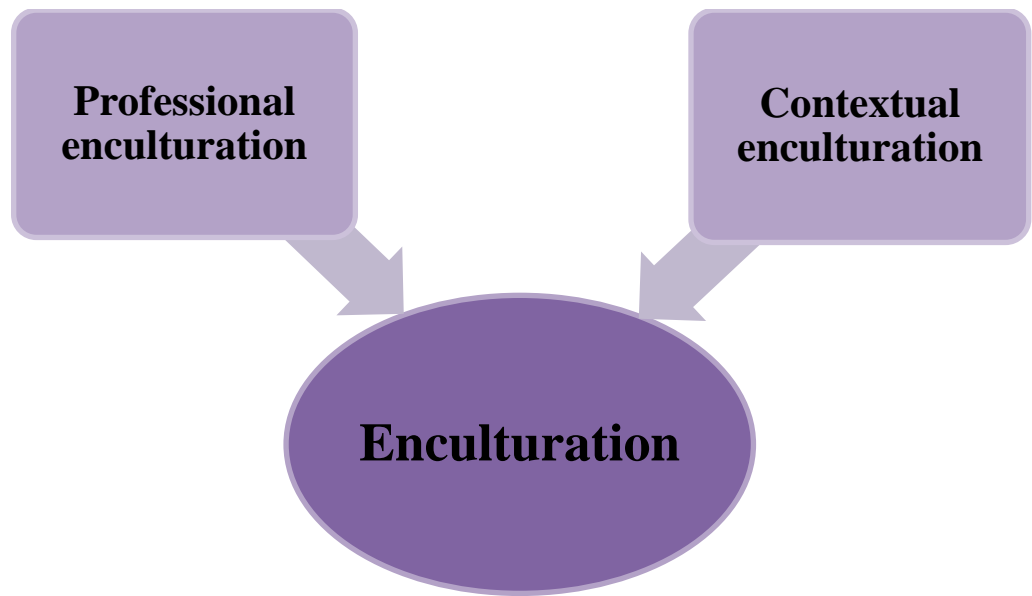


Figure 20: Enculturation

In this study, varying notions of **enculturation** emerged consistently in discussions with NUMs and BNPCs as significant contributors to graduate RN practice readiness. Two sub-categories emerged from the data in relation to the notion of **enculturation**. These were: **professional enculturation** and **contextual enculturation**, which are presented diagrammatically in Figure 21.

Professional enculturation was referred to by participants as one aspect of enculturation. In this study, **Professional enculturation** is about attaining the desired graduate attributes that participants believed were significant contributors

to graduate RNs practice readiness. These attributes were considered by participants as essential to developing the professional role of the generalist RN who is required to meet the *National Competency Standards for the Registered Nurse* (NMBA 2006). The other aspect of enculturation that was described by participants was **contextual enculturation**. This concept is about newly graduated RNs being familiar with the intricacies of the local context and having the ability to develop a sense of belonging, i.e. coming to terms with and understanding the local clinical context where graduates are usually employed.

Both BNPC and NUM participants agreed on the significance that **professional enculturation** and **contextual enculturation** had for graduate RN practice readiness. However, opinions differed as to the focus and timing when graduate RNs should attain contextual and professional enculturation and what a new graduate can and can't be expected to do on entry to practice. Such variation in focus emanates from the fact that NUMs and BNPCs view newly graduated RNs practice readiness through different lenses as a result of **Inhabiting Disparate Realities**. **Professional enculturation** and **contextual enculturation** will be elucidated in greater detail commencing with discussion on **professional enculturation**.

Professional Enculturation

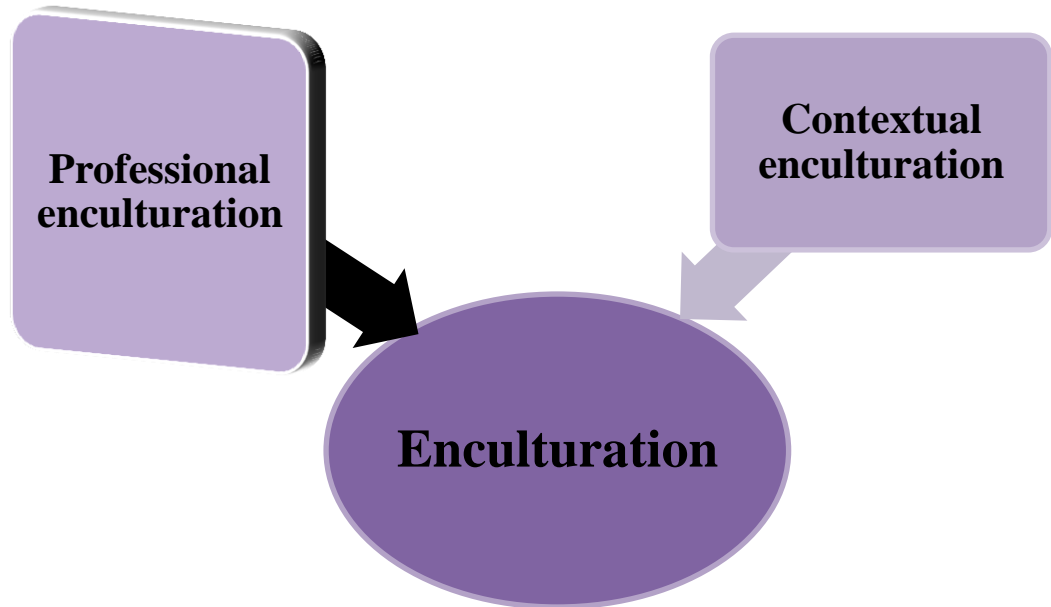


Figure 21: Professional Enculturation

Professional enculturation (Figure 21) is one notion of **enculturation** that emerged consistently in interviews with NUMs and BNPCs. The following participants' excerpts and reflections illustrate the emergence of the sub-category **professional enculturation**.

Participants identified a series of desirable attributes as significant contributors to graduate RNs practice readiness. Participants described a graduate RN who possesses these attributes as someone who is a '*critical thinker*'; '*reflective practitioner*'; '*life-long learner*'; '*good communicator*'; '*team player*'; and someone who is '*safe*', '*caring*' and '*able to perform basic clinical skills*'.

The following excerpt highlights the desired graduate attributes discussed by a NUM:

P 7 (NUM): *So you mightn't know everything but do you have the ability to learn quickly and adapt. Aptitude and also attitude ... so basically a positive attitude towards learning ... and, the last one for me, probably a broad theme around teamwork.*

With regard to the attributes that graduate RNs need to recognise their own limitations and be life-long learners, one participant suggested that:

P 5 (BNPC): *... we can't possibly teach them everything in the three year undergraduate bachelor degree, but what we can teach them is to learn. ... we expect new graduates to have a sound theoretical base of knowledge ... they need to know their own limitations. They have to be responsible for their own learning, so we really are trying to engender in them this notion of lifelong learning.*

Additionally participant 4 said ...

P 4 (BNPC): *... we've only given them the building blocks, I guess, to be a registered nurse and now they have got to actually learn how to use those building blocks.*

Another participant also described the desired attributes for a graduate RN and highlighted the need to be a reflective practitioner and to be able to identify their learning deficits. This participant suggested that graduate RNs should be ...

P 4 (BNPC): *... able to reflect on their own level of competencies, their own level of knowledge, to be able to figure out answers and to know where there's deficits.*

With regard to the graduate attribute of being a critical thinker and a good communicator, one participant suggested:

P 10 (BNPC): ... *we'd like them to be critical thinkers, ... we expect that they're professional in their appearance, but also in their communication and to work within the guidelines of their scope of practice of a registered nurse according to ANMC.*

Another participant said ...

P 14 (BNPC): ... *they have to have good communication skills ... and to work well within a team.*

As well as possessing basic clinical skills, participant10 suggested that a desired attribute that contributes to graduate practice readiness is being a safe practitioner:-

P 10 (BNPC): ... *when they [graduates] start their first year of practice, we would like them to come out with the skills of a beginner registered nurse and they are able to practice safely and competently in the environment ... within their scope of practice and within the ANMC guidelines that we use as our basis. ... we say they are safe to practice.*

A NUM also highlighted the need for graduate RNs to be safe and caring and to be able to perform basic clinical skills. With regard to the significance of being a safe practitioner, this NUM suggested:

P 12 (NUM): ... *the main thing is that they need to be safe. ... I can teach them to suction, I can teach them to change tracheostomy tubes, but you can't really teach them to be safe ... not to go ahead and do a procedure they're unfamiliar with, that ... they know what the medications are and the effects of the medications before giving them, rather than just saying "I'm in a hurry".*

The same NUM added the following with regard to being caring:

P 12 (NUM): *One graduate nurse ... I worked with recently, she came into the profession because she loved caring for patients, and you could see that in her, like*

nothing was too much. If she was busy doing a dressing or whatever, and the patient asked for a cup of tea, she didn't think "Oh that's the tea lady's job to get that", she went and made the patient a cup of tea, gave it to them and continued with her work, nothing was too much for her you know, ... even if she doesn't know, she'll come to a senior staff member and say "I'm not really sure how to do it, I think it's important that the patient gets this review or that review".

Another participant also highlighted the significance of being a caring person as a desired graduate attribute:

P 9 (BNPC)... *hopefully they'd be caring and empathetic.*

Attributes of someone they considered would be practice ready were suggested by a participant who described that ...

P 8 (NUM): *... their time management is good, they're able to manage their workload. ... they know how to ask questions, ... if they're unsure, they ask, they don't just flounder on and hope that it's going to get better. ... they show some initiative. ... there was this brand new grad talking to a patient and his family about his Parkinson's disease and his medication with confidence, explaining to him, and I just stood outside the room and listened for a bit, and it was wonderful, you know, just to hear the confidence in her in being able to discuss the disease process and put the practicalities in about the medication and what effect it has. ... I think a lot of it is the individual, you know, and how committed they are.*

The need for graduate RNs to be critical thinkers, lifelong learners and good communicators was voiced by the following BNPC. This participant also suggested that graduates' clinical skills and time management are inclined to improve with time and practice:

P 13 (BNPC): *... in terms of knowledge and critical thinking and more global skills like communication, graduates are probably better prepared now than what they ever have*

been. In terms of ... things like skill level and time management, perhaps they are not, but I think they are things that they pick up in their graduate year quite quickly.

In relation to the significance of being able to perform basic clinical skills, the following participants suggested that graduate RNs should:

P 12 (NUM): *... have those basic skills of being able to talk to the patient, shower the patient, inspect their skin, you know, look at their mobility rather than just "I'm in here, I'm gonna do a big VAC dressing and change this tracheostomy tube" but forget that the patient can't turn themselves and end up with a pressure injury.*

P 9 (BNPC): *... graduates should have really good core general nursing skills ... a good example of that would be things like administering medication, aseptic techniques, you know, those types of foundational nursing skills ... they would be really good at those.*

However, one NUM argued that some graduate RNs were unable to perform basic clinical skills:

P 1 (NUM): *I actually commented to the University that I felt that the guys were very very under prepared at times. ... simple skills, even the use of equipment, they would be terrified, they were very unaware of how to use them. ... They can look after the patients but you know when colleagues are asking them to do certain things, you can see the panic in their face because they really have no clue how to do these things but then it has a domino effect ... and then things get missed.*

Another NUM voiced a similar concern by adding that

P 2 (NUM): *... they [graduates] struggle with trying to manage time and basic nursing care sometimes gets missed out.*

In response to concerns made by NUMs regarding graduate RNs lack of mastery of clinical skills, a BNPC acknowledged the focus on other graduate attributes:

P 10 (BNPC): ... we [nurses] have a focus on the clinical skills, I don't want to underestimate that because we do want them [graduates] to be comfortable and safe in the practice in doing these skills, but we do focus a lot on critical thinking and reflective practice.

The above discourse and reflections illustrate that the sub-category **professional enculturation** is about attaining the desired graduate attributes believed by participants to be significant contributors to graduate RNs practice readiness. Such desired graduate attributes include being a '*critical thinker*'; '*reflective practitioner*'; '*life-long learner*'; '*good communicator*'; '*team player*'; and someone who is '*safe*', '*caring*' and '*able to perform basic clinical skills*'.

These attributes are thought to be essential to the development of the professional role of the generalist RN capable of working in multiple clinical settings. However, when it comes to graduate RNs practice readiness, NUMs and BNPCs appeared to have varying priorities and expectations. Once again, illustrating participants **Inhabiting Disparate Realities**. NUMs and BNPCs viewed these graduate attributes through different lenses. NUMs expected such desired graduate attributes to be fully developed at the time of employment while BNPCs thought they can mature with time. This concludes the discussion on the sub-category **professional enculturation**. **Contextual enculturation**, the second sub-category of **enculturation** is now considered.

Contextual Enculturation

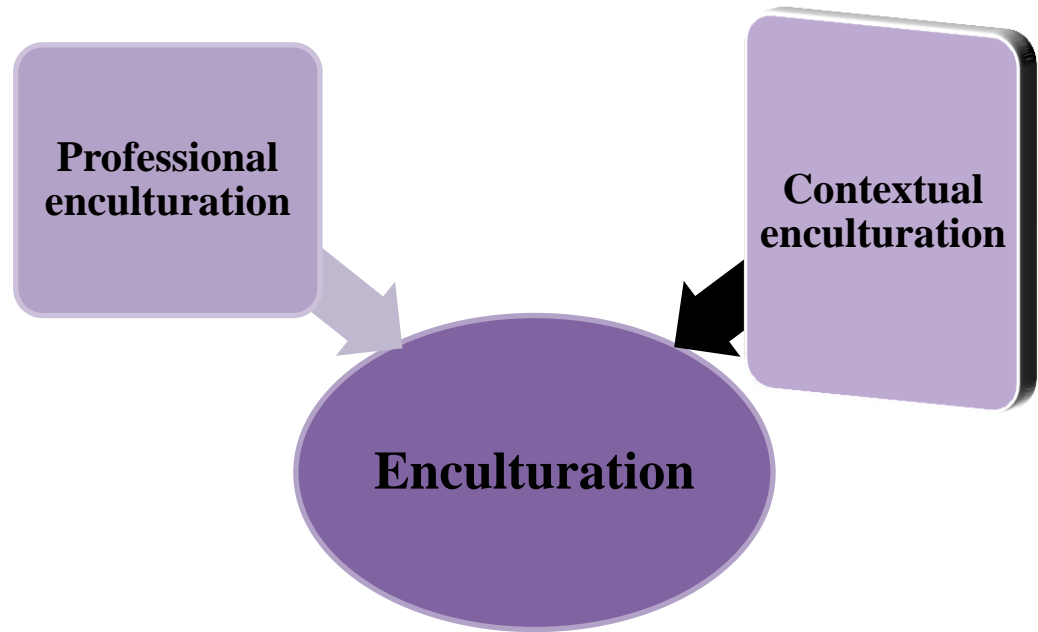


Figure 22: Contextual Enculturation

The sub-category **contextual enculturation** (Figure 22) is another notion of enculturation that emerged consistently throughout the data. As explained earlier, **contextual enculturation** is about familiarity with the intricacies of the local context and the ability to develop a sense of belonging, i.e. coming to terms with and understanding the local clinical context where graduates are usually employed. A NUM described **contextual enculturation** as:

P 1 (NUM): ... *getting to know people and getting comfortable in your environment.*

Participants claimed that **contextual enculturation** is a necessary antecedent to newly graduated RNs practice readiness as it enhances their transition experience and lessens their culture shock. This is illustrated by the following participants' reflections:

P 3 (NUM): ... people [graduate RNs] who have experienced prac within the hospital environment and an acute environment tend to 'oh I'll go do this' 'oh I'll go do that' 'can I help you with this' rather somebody who stands there and is waiting to be told what to do.

P 12 (NUM): ... they've got a better understanding because they've spent a longer period of time with us. ... they familiarise themselves with the routine of the ward, and they know that at this time we usually do handover, at this time we give out medications, this time we have a ward round, but also they become more familiar with the staff, therefore they are a little less apprehensive about asking more senior staff for assistance or advice compared with some of the ones that have been there a shorter period of time as a student.

P 16 (NUM): I think it probably makes the grads feel less stressed ... when we have students that are coming back to the wards as grads, they're already familiar with the wards and, you know, people on it, they know how the ward works and ... they are not having to pick up all those basic things because they already know it, you know, ... where things are kept and it's all those little things that probably take up time for grads ... their time management is going to be a big thing for them, you know, no-one likes going into an unfamiliar environment.

Participants described how contextual enculturation was important and spoke about the consequences that might arise for newly graduated RNs who were not contextually enculturated. Two participants described the implications of newly graduated RNs not being contextually enculturated and stated that it contributes to them being ineffective in the initial stages of employment:

P 5 (BNPC): I see students who have that kind of rose coloured glasses view of another health service, that they've potentially never been to, but because they believe it has a better reputation or because they like the specialties that it offers, they end up working there in their graduate programme ... but they're not enculturated into the organisation in any way at all, and had all of their placements elsewhere and they're trying to bring the things that they've learned elsewhere and ... it's part of what I think contributes to them being ineffective in their first especially initial couple of weeks. And their

expectations are often misplaced because there's no knowledge of the organisation or the staff or the way the organisation works, so they think that what they've encountered elsewhere will be automatically recognisable elsewhere, and it's simply not the case.

P 3 (NUM): *It's when you walk on a ward, ... you know what jobs there are to do, even working with a planner. When somebody comes up and says 'oh no I've not seen one of these before' your heart sinks because everybody uses planners. So you know they've not been in an environment that works in this way. ... You're having to start from scratch with some people. It's really really difficult.*

The sub-category **contextual enculturation** as posited by participants is about newly graduated RNs being familiar with the practice guidelines and clinical standards that are used in the clinical context where they are employed. The following discourse illustrates this:-

P 7 (NUM): *... having the same student in an organisation, hospital, or even at a district level throughout their three years ... there's a win-win in the model where hospitals engage in that rather than the current system.*

Illustrative of the sub-category **contextual enculturation**, and indicative of the notion that many participants wanted to solve what they perceived as the problem, participants discussed the paid employment of students within health services as a strategy. They suggested that such a strategy facilitated familiarity within a clinical context and enabled students to develop a sense of belonging, which was considered an important attribute for newly graduated RNs to possess.

P 4 (BNPC): *Well one of the ... good moves in the last year or two, is the employment status of a student within the health care setting ... that's really great because it gives them that, that, enculturation into the health care environment, gives them a chance to practice the skills they're learning as students and gives them a sense of belonging and I think that should be used a lot more for students and I know some hospitals are starting to do that and I think that's great.*

P 6 (BNPC): *It [student employment] does improve their time management. It does make them more confident. They feel more part of the hospital culture.*

Similarly, a NUM discussed the value of **contextual enculturation** and how it could be achieved by graduates being employed in the same clinical environment where they complete their clinical placements:

P 12 (NUM): *A lot of the times we pick graduate nurses if they have been with us for a while and we've actually seen their behaviour. But what I do find, is that as students, ... spend the three month block with us, when they come back as a graduate nurse, they've got a better understanding because they've spent a longer period of time with us. ... they familiarise themselves with the routine of the ward, and they know that at this time we usually do handover, at this time we give out medications, this time we have a ward round, but also they become more familiar with the staff, therefore they are a little less apprehensive about asking more senior staff for assistance or advice compared with some of the ones that have been there a shorter period of time as a student.*

As another illustration of participants seeking solutions, some suggested that **contextual enculturation** could be achieved through clinical placement modelling. One participant offered the following:-

P 5 (BNPC): *Why not move the selection process [of graduates] forward? Why not do it at the end of second year instead of third year and then provide third year places to whomever you selected regardless of what university they go to.*

On the same topic, another participant suggested that ...

P 4 (BNPC): *... the student actually applies to go to a particular health care setting and there are almost interviews set up and that student stays in that same placement and ... then the health care centre would have more commitment to those students if they've interviewed them and they've chosen them to some extent. ... I think that type of system would work quite well.*

The significance of graduates being contextually enculturated was highlighted by a participant who discussed the value of linking clinical placement to the employment of graduates and suggested:-

P 5 (BNPC): *... we need to start thinking about preparing students in their final year of practice to work in a particular environment. I sort of think the model where we have clinical schools in hospitals ... where they [students] become direct feeders for graduate nurse programmes as opposed to a student having placements where the University can seek the placement and then [students] applying for a graduate position in another field, in another environment, in another health care service where there is no economy in terms of what they've learned that is health service specific, is no use to them elsewhere. So that they can overcome some of the idiosyncrasies involved with individual health services and, perhaps, that would improve their work readiness.*

A BNPC also suggested that **contextual enculturation** lessens the impact of culture shock:

P 13 (BNPC): *... in the last year of their degree our students spend 6-8 weeks fulltime in clinical placement ... in acute care the students spend eight weeks at a time without a break in the clinical environment. So they become very familiar with that particular environment. And often we find that the graduates that do well are the ones that go back to that environment. So they are already familiar with the policies, the protocols, they're familiar with the staff, they're familiar with the ward layout and from my perspective, I've noticed that there is a huge correlation between students being successful in a particular environment and their last clinical placement in acute care and often now, when the graduate transition officers are looking to place students [graduates] they will actually try and place them back in the area that they spent their acute care placement, because we just know it's so much easier, because they already know people and people are familiar with them and so that is really positive ... by putting a student [graduate] back in an environment that they're familiar with, particularly for their first rotation, you've lessened that impact of culture shock.*

A similar viewpoint was expressed by a NUM participant who argued that ...

P 16 (BNPC): ... *the beauty of them [graduates] being students here before they start as grads because all that feeling comfortable, you know, there's no surprises, they're coming back to where they've been before and they know people by name and it's not an unfamiliar environment so I think that's where I see the importance of that following through from their placement to their grad year.*

The transition from student to RN is thought to be challenging. Induction is a strategy usually used to familiarise new employees with their role expectations and accountabilities. As such, the following participant suggested that newly graduated RNs who are contextually enculturated are thought to be “easier” to induct into a clinical setting:

P 6 (BNPC): *If you employ someone locally who's done clinical placements with you in terms of orientation and everything, it is a lot easier, from a management perspective.*

Once again, different lenses are apparent. This is illustrated in the following excerpts that portray a variation of focus and timing of **contextual enculturation**. As presented earlier, some participants suggested that **contextual enculturation** should be attained prior to employment to enhance the transition experience of newly graduated RNs, which was thought to be a necessary contributor to graduate RN practice readiness. However, some participants asserted that **contextual enculturation** should occur primarily upon commencement of employment as a graduate RN:

P 11 (BNPC): ... *they [graduates] require a period of orientation and adjustment to whatever setting they are in to get their heads round specific policies, processes and procedures in the setting in which they work in.*

P 4 (BNPC): ... *they [newly graduated RNs] need to be mentored so they feel like they belong and they need to be given a chance to build that sense of belonging in some way.*

Contextual enculturation, as illustrated by the above discourse and reflections portrays the significance that this sub-category had for participants. However, where opinions differed was on the focus and timing of when graduates should attain **contextual** and **professional enculturation**. Some participants suggesting **contextual enculturation** should already be developed upon commencement of employment to enhance the transition experience of newly graduated RNs, and others asserting that it should occur post-employment.

This concludes the discussion on the two emerging sub-categories, namely, **contextual enculturation** and **professional enculturation**, which informed the category **enculturation**. Relevant quotes are now presented to discuss the third and last category, namely, **hit the floor running**.

Hit the Floor Running



Figure 23: Hit the floor running

Figure 23, depicts the category **hit the floor running**, which reflects the expectations of newly graduated RNs to **hit the floor running** upon employment as a result of varying **system drivers**. As discussed earlier, the findings from this study revealed that most participants recognise and acknowledge that newly graduated RNs are novice clinicians. They also appear to recognise that **professional** and **contextual enculturation** contribute to graduate practice readiness. However, it appears from the data that varying **system drivers** have shaped participants' perspectives and informed their priorities and expectations regarding newly graduated RN practice readiness. The consequences of which are that whilst acknowledging newly graduated RNs are novices, they are also expected to **hit the floor running** as they commence employment.

Several participants expressed views that graduate RNs are prepared at novice level. One BNPC suggested that:

P 9 (BNPC): ... *they [graduates] would be a beginning level practitioner who could meet all the ANMC competency standards, but at a beginning level, so at a novice type of level.*

A NUM concurred with the notion that graduate RNs are prepared at novice level but suggested that despite this, the expectations of novice graduates are too high:

P 7 (NUM): ... *the expectations we have of our new graduate population ... are too high.*

Participants provided a clear indication that graduate RNs even though considered novices, were generally expected to hit the floor running. One NUM stated:

P 1 (NUM): *I know that there is an expectation from staff ... that they [graduate RNs] should come onto the floor running.*

Another NUM concurred, stating:

P 12 (NUM): *... it is an expectation, pretty much, that they [graduates] hit the floor running.*

One NUM offered a rationale for why graduates were expected to hit the floor running by explaining that:

P 3 (NUM): *They're [graduates] not given a lighter case load. They're given the same back-up, the same Enrolled Nurse, the same team as any other RN. You can't say "ohh we'll really give you the lightest" it doesn't work like that in the real world. They come out and they run the same as everybody else. ... there is actually nothing on their uniform to say I've been nursing 3 days.*

The significant role NUMs can play in supporting graduates as novices, even when they have to hit the floor running, was implied by the following:

P 7 (NUM): *... it's about setting the permission to say 'we're here to support you, you've got the broad abilities as a registered nurse, you've got some foundational ingredients as a graduate nurse, ... there are some clinical skills that you will develop over time to reach a level of competence ... and confidence ... there are simple things you [NUMs and other clinicians] can do that obviously make the transition from a poor learning environment to a good learning environment, easily done.*

A BNPC also commented on the role that NUMs can play in supporting graduates by providing them with supervision and enabling them to work within their scope of practice. One participant stated that:

P 10 (BNPC): *They can hit the floor running as far as they're competent and safe to practice at the novice nurse level, so obviously as a NUM you don't allocate the severely complex patient to that nurse, you give them the patients that they can manage.*

The following insights were also offered:

P 11 (BNPC): *My experience is that some managers, some NUMs value and appreciate the fact that they need to invest time and energy and "resources like money", to support new grads to get them embedded well into their workplace, to feel positive and that they can contribute and feel valued as a consequence of that.*

and ...

P 9 (BNPC): *... some services offer really supportive graduate programmes, where the student [graduate] will be preceptored and working supernumerary for a couple of days, or in some cases I've seen up to a week, the graduates being supernumerary.*

One BNPC however, reflected on recent changes with regard to the support afforded to graduate RNs. This participant believed that even though graduate RNs might be better supported in recent times, they are still expected to perform at an expert level rather than at a novice level:

P 10 (BNPC): *... from the time that I graduated and...compared to what the students [graduates] get now, they're getting a lot more support than we ever did, and yet it doesn't seem to be resolving the problem. Maybe our expectations are too high...maybe when we say we want them work ready we mean we want them work ready at the expert level and not the novice level.*

Some graduate RNs might be deluded by unfulfilled promises of support and education in their first year of employment according to Participant 13:

P 13 (BNPC): *Agencies come and talk to students and say "look we have these wonderful graduate programmes and we are going to do this and that", but from my experience talking to new graduates and I also still work in practice alongside new graduates ... there is no support, really ... the majority of them are completely unsupported.*

In this regard, the following participant claimed that graduate RNs usually expect more support than they actually get:

P 5 (BNPC): *... they're [graduates] looking to be supported to a level probably higher than the health services provide to them, and so many of them...um...they survive in the first three months in that, sort of, school of hard knocks.*

The same participant went on to say:

P 5 (BNPC): *... many of them [graduates] don't feel intellectually or emotionally prepared for what's going to be expected of them and they don't cope particularly well.*

Some graduate RNs might not have opportunities to debrief:

P 6 (BNPC): *... they [graduates] haven't got any avenue to say 'Hey I did this, what did you do? Hey I saved someone's life and they thanked me and it suddenly dawned on me that's why I did the course'.*

And the same participant described how this lack of support could lead to some graduate RNs feeling disillusioned with the nursing profession:

P 6 (BNPC): *... the feedback that I'm getting when they're in tears, is the sudden realisation that 'I haven't got time to talk to the patient or the family, I am purely doing tasks. If I can wash the patients, do my meds, do my IV's, do this...and that's my planning chart for the day, ... if the patient or the family wants to talk to me, ... I've only got half a minute. I'll be behind with my meds. And if I have to do a MET call or something, that's the rest of my patients – gone!*

A NUM also voiced a similar view and linked graduate RNs feeling disillusioned with the notion of leaving the profession. This NUM stated that:

P 8 (NUM): *... my concern is that we lose nurses because they are not ready and they go in and they can't cope with the stressful environment, there is no-one to be able to support them and so that's a vicious circle.*

Third year students are expected to be able to manage a full load of patients at the end of their final clinical placement. One BNPC demonstrated this by saying that:

P 6 (BNPC): *... my expectation is at the end of those eight weeks they should be managing a full patient load and ... at the end of internship [final clinical placement] you [the RN supervising the student] have to be prepared to accept these people as your colleagues. You [the RN supervising the student] have to be prepared to say 'ok I would work a shift with them tomorrow'. ... they should be functioning as an RN, they should be taking on the full RN role ... I've spelt it out to the buddy nurses and the facilitators, if you're not prepared to work with them as a colleague tomorrow and give them a full patient load, there's something wrong, because that's the ultimate aim, there is no next semester.*

The expectation in the clinical setting is that:

P 9 (BNPC): *... they do need to hit the floor running, and those first three months are crucial to the student's [graduate's] experience in becoming the registered nurse in that role*

and ...

P 2 (NUM): *... they come in and they're on full shifts ... so it's a big big ask for them to come in, it's such a massive change ... you know from doing 4 weeks here and 4 weeks there to come and do 3 months of full shift work.*

Expecting graduate RNs to hit the floor running was described by a NUM, who discussed how the support of graduate RNs might positively impact the retention of the nursing workforce.

P 8 (NUM): *... that's very short-sighted and as NUMs ... I think we need to be looking at the bigger picture, keeping, encouraging these people to stay in nursing ... our responsibility is to support grads so that they stay in the profession. I need somebody to look after me.*

Participants suggested the need for a different registration model to ensure that graduates are easily identified as novices in the clinical setting:

P 4 (BNPC): *... I would really like it if there were some other way of registration for the first year, that they are registered as beginning RN or something in that way ... and not put under the pressure of being an RN that is capable of looking after a number of patients in a very competent way.*

The significance of using a different term like “Internship” that is used within the medical profession was identified by participants. This would ensure graduate RNs are identified by all clinicians as novices.

P 13 (BNPC): *I certainly know from working with medical graduates ... like when they say to me "I'm an intern", it makes it very clear as to where they're at and I think "oh, ok, you need a bit more support", and I think, to use that consistent language, practice would actually be good for when we say "I'm a graduate nurse", you just think "oh, ok", if they were to say "look, I'm an intern", it lets everybody know that, you know, here is a person that, yes, they've done a Bachelor of Nursing, they've done a degree, they are obviously intelligent ... we hope ... intelligent, articulate individual who just needs more support in their graduate year. But I think changing the language around what we call "new graduates" would help to a degree.*

A participant acknowledged the health services' dilemma with regard to their expectations of the novice graduate RNs and argued that:

P 5 (BNPC): ... *I think they [health services] genuinely want us [universities] somehow to produce work ready graduates. They want people [graduates] who can come in, and sure, they might not need, or be able to do everything, but they expect them to be able to function in a useful, contributory sort of fashion from day one.*

It became apparent from the data that there is a tension between the two different notions. On one hand, participants are clearly affirming that the BN programme prepares novice clinicians and on another hand, these novice clinicians are expected to hit the floor running and behave and carry a case load the same as other more experienced RNs when they join the health services. As a further illustration of this tension, one BNPC expressed their frustration with employers who continue to expect new graduates to hit the floor running. This participant declared that:

P 4 (BNPC): ... *they're [graduates are] at the beginning of their journey and they really won't be ready to be on the floor running. ... I've heard that from a couple of Directors of Nursing now that they would like for them to hit the floor running.*

Similarly, another BNPC argued that graduates are not usually work ready at completion of the BN degree and that working as graduate RNs contributes to them becoming work ready:

P 5 (BNPC): ... *if you look at a graduate after six months, they're actually at that kind of work ready stage, albeit as novices, that potentially the health services are looking for. But it's likely been the six months of practice that's got them there, not really the preparation they've had in their course.*

The following BNPC highlighted the unrealistic expectations of graduate RNs in comparison to graduates of other health disciplines:

P 13 (BNPC): *It's not something we expect of virtually any other profession. We don't expect brand new engineers to hit the floor running and we don't expect medical staff to do it and we don't expect physiotherapists to do it and it's interesting that we sort of had almost this culture emerging in nursing that we expect graduate nurses to be fully functioning the first day that they hit a ward and from my perspective we just expect far too much of them. You know, that first graduate year is a huge learning curve and I just think to expect a new graduate to be a fully functioning registered nurse from Day 1 is just ... is just ludicrous, really. Sorry ... I can't think of a better word. It's just crazy. We just put so much pressure on them from the outset and, you know, we need to look at the way that other professions support their new graduates, so we wouldn't expect a brand new intern on their first day to go in and do an appendectomy unsupervised and unsupported, but we seem to expect it of nursing students and I think it's really sad that we do that. It almost goes back to that culture of eating our young. It doesn't happen so much now, we don't tend to eat the students, but it's almost like we've taken it up to that next level where we will wait till they graduate and then we'll eat them.*

Voicing a similar view, a different BNPC added:

P 10 (BNPC): *As far as the problem with the time management thing goes, we believe that it doesn't matter what position you're in, whether it's doctor, lawyer, solicitor, engineer, it's not until you're actually out there in the workforce working, you know, those skills get developed and your improvement of time management comes with time. ... we recognise that of course that not everyone is going to be work ready as far as having time management skills of an experienced 10 years registered nurse.*

Exploring the perspectives of NUMs and BNPCs regarding newly graduated RN practice readiness led to the emergence of the substantive theory of ***Practice Readiness: A Nebulous Construct***, which is illustrated in Figure 24.

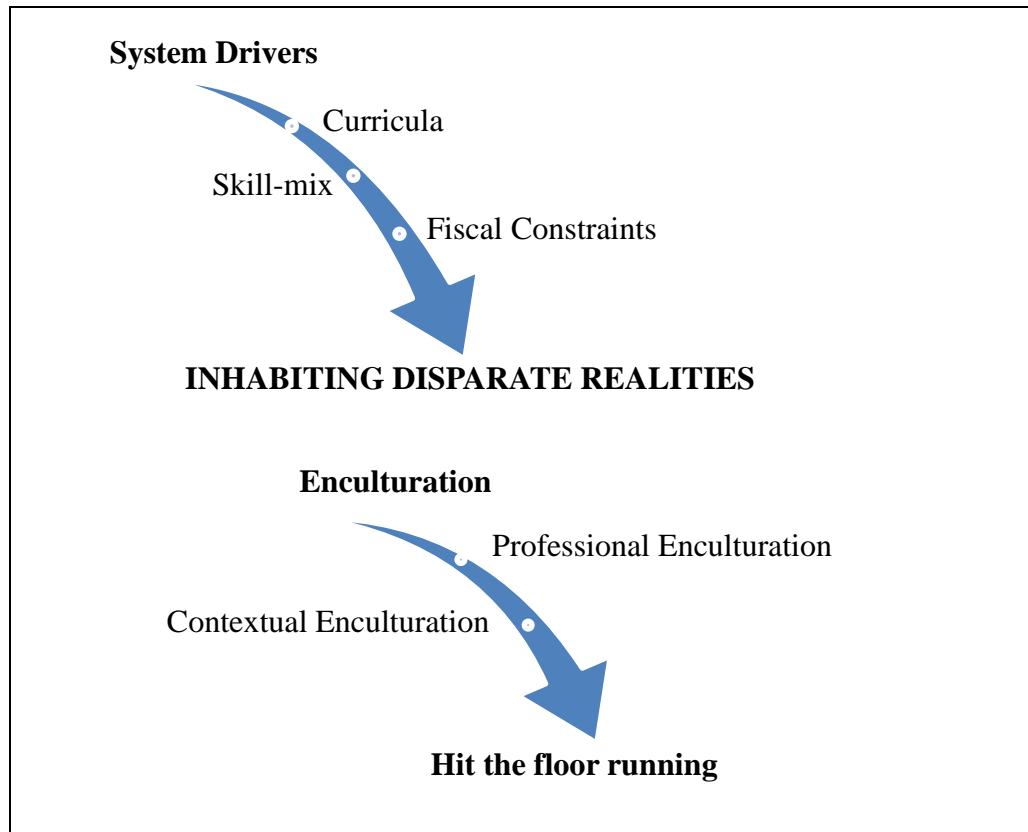


Figure 24: The substantive theory
Practice Readiness: A Nebulous Construct

As a result of varying **system drivers**, the perspectives and expectations of NUMs and BNPCs differed as to the focus and timing when graduate RNs should attain **professional** and **contextual enculturation** and to what a new graduate can and can't be expected to do on entry to practice. Such perspectives and expectations speak to the tension that is inherent in the notion of a novice graduate RN expected to **hit the floor running**. Fundamentally, participants acknowledged that newly graduated RNs are novices but their perspectives and expectations varied as a result of **Inhabiting Disparate Realities**, perpetuating the perception that newly graduated RNs are not practice ready in the Australian context. This is evidenced in the following:

- Some participants suggested **contextual enculturation** should be attained prior to employment to enhance the transition experience of newly graduated RNs, and others asserting that it should occur post-employment.
- NUMs expected desired graduate attributes to be fully developed at time of employment while BNPCs think they can mature with time.
- Focusing on preparing a generalist RN, BNPCs offer broad and comprehensive BN curricula that expose students to varying clinical contexts, while NUMs call for longer exposure in acute clinical settings.
- NUMs have to ensure patient safety while at the same time working with staffing models that don't recognise the graduate RN as a novice clinician but simply as an RN on a roster.
- NUMs and BNPCs have to manage fiscal constraints that limit universities from offering additional clinical placement hours than the required minimum (800 hours in Australia) and NUMs from offering additional or sufficient supernumerary days or education time to their novice graduates.

This concludes the discussion on the emerging core category **Inhabiting Disparate Realities** and the three categories that informed the substantive theory *Practice Readiness: A Nebulous Construct*.

Chapter Summary

This chapter presented the research findings, which informed the conceptual emergence of the substantive theory *Practice Readiness: A Nebulous Construct*. Participant narratives demonstrated epistemological dissonance as a result of

contextual influences that are pragmatic and are shaped by their **Inhabiting Disparate Realities**.

The findings revealed that both cohorts of participants acknowledged that **professional** and **contextual enculturation** contribute to graduate practice readiness. However, participants' opinions differed as to the focus and timing of when graduate RNs should attain **professional** and **contextual enculturation**. It is this divergence in opinion, as a result of varying **system drivers** that shaped participants' perspectives.

The chapter described varying **system drivers**, which included **curricula**, **skill mix** and **fiscal constraints**. All of which contribute to the core category of **Inhabiting Disparate Realities**. **Inhabiting Disparate Realities** fundamentally means that NUMs and BNPCs view newly graduated RNs through different lenses. In addition to this, the chapter discussed how **Inhabiting Disparate Realities** shaped participants' perspectives and expectations regarding practice readiness, leading to novice graduates being expected to **hit the floor running**. Hence, illustrating the emergence of the substantive theory namely, ***Practice Readiness: A Nebulous Construct***.

Chapter Five provides a discussion of the findings. The discussion incorporates the established knowledge within the literature in relation to the notion of graduate RN practice readiness, **system drivers** and varying notions of **enculturation**, and will explore the notion of novice graduates being expected to **hit the floor running**.

CHAPTER FIVE

DISCUSSION

Introduction

This chapter builds on *Chapter Four*, which presented the findings of this study exploring the perspectives of NUMs and BNPCs, regarding newly graduated RN practice readiness in the Australian context.

As discussed in *Chapter One*, the impetus for this study grew from the researchers' personal experience of the enduring difference of opinions expressed by clinicians and academics as to whether newly graduated RNs are, in fact, practice ready. The substantive theory offered in this thesis, provides an account for the longstanding debate on this issue by explaining the divergence in understanding of NUMs and BNPCs regarding newly graduated RNs' practice readiness in the Australian context. In this study, participant narratives demonstrated epistemological dissonance due to contextual influences that are pragmatic and are shaped by their **Inhabiting Disparate Realities**. Such epistemological dissonance perpetuated the perception that newly graduated RNs are not practice ready.

This chapter considers the study's findings in light of existing literature. This serves to highlight alignment with existing research but also demonstrates the unique and significant contribution this study makes to the body of nursing knowledge. In order to do so in a logical and readable fashion, this chapter presents a comprehensive discussion of the emerging substantive theory, the core

category, and each of the three categories with their associated sub-categories, in the order they were presented in *Chapter Four*. The search strategies used in this deeper engagement with the literature are now presented.

Re-visiting the literature in relation to the findings

Despite the fact that literature search strategies are usually complex, Finfgeld-Connett and Johnson (2013) urge researchers to maintain transparent processes to enhance the integrity of ‘knowledge-building and theory-generating qualitative systematic reviews’ (p. 194).

In this study, re-visiting the literature in light of the findings but in far greater detail encompassed a review of nursing, health more broadly, management and education literature. Electronic databases including CINAHL, Scopus, ScienceDirect, ProQuest Central, MEDLINE, Ovid, and search engines like EbscoHost, Google and Google Scholar were also used to identify appropriate literature for close examination. Search terms included: nursing education; nursing workforce; transition; culture shock; reality shock; practice readiness; work readiness; fitness for practice; graduate nurse; recruitment and retention; belongingness; clinical placement; clinical exposure; workplace exposure; enculturation; socialisation; graduate attributes; skill-mix; staffing ratios; health budgets. Only full text, peer reviewed papers published in English were considered. Furthermore, grey literature and secondary references were utilised as the researcher carefully scrutinised reference lists and searched government and other websites such as:

- Australian Bureau of Statistics (ABS): <http://www.abs.gov.au/>
- Australian Health Practitioner Regulation Agency (AHPRA):
<https://www.ahpra.gov.au/>
- Australian Nursing and Midwifery Accreditation Council (ANMAC):
<http://www.anmac.org.au/>
- Health Workforce Australia (HWA): <http://www.hwa.gov.au/>
- International Council of Nurses (ICN): <http://www.icn.ch/>
- Nursing and Midwifery Board of Australia (NMBA):
<http://www.nursingmidwiferyboard.gov.au/>

Having offered an explanation as to the process of undertaking the search strategies so as to engage with the literature, this chapter will now focus on how the substantive theory that emerged in this study, relates to existing literature.

The Substantive Theory

As discussed in *Chapter Three*, theories are classified as either formal or substantive. A formal theory is developed to a higher level of conceptualisation and is usually applicable across a wide number of substantive areas (Birks & Mills 2011). A substantive theory, on the other hand, is a pragmatic explanatory theory developed for the purpose of understanding a specific social phenomenon or social pattern (Glaser & Strauss 1967). According to Glaser (1978, p. 142), a substantive theory ‘fits the real world, works with predictions and explanations, is relevant to the people concerned and is really modifiable’. It is a substantive theory that is offered in this thesis.

Throughout this study, the researcher followed Glaser's (1992, p. 22) approach by consistently examining 'what is going on that is an issue and how it is handled?' The use of the constant comparative method of data analysis has resulted in the conceptual emergence of the substantive theory ***Practice Readiness: A Nebulous Construct***. Like other substantive theories, that which is offered in this thesis provides an explanation of the perspectives of NUMs and BNPCs regarding newly graduated RNs' practice readiness.

This nebulous nature of practice readiness is underpinned then, by the lack of clarity around the expectations of what newly graduated RNs 'should' be able to do and the level of responsibility they 'should' be able to take on, upon entry to practice (Casey et al. 2011; Watt & Pascoe 2013; Wolff, Pesut & Regan 2010). The unrealistic expectation to produce RNs who can hit the floor running (Romyn et al. 2009), the perceptions of lack of graduate preparedness for practice and their ability to function as RNs upon graduation (Evans, Boxer & Sanber 2008; Monaghan 2015; Romyn et al. 2009; Usher et al. 2015; Wolff, Pesut & Regan 2010), highlight the nebulous nature of practice readiness.

Interestingly more than a decade ago, Holland (1999, p. 235) in an ethnographic study that explored the nature of transition in the UK, asserted that 'the transition of the student nurse to qualified nurse was not a clearly defined event'. A decade later, Wolff, Pesut and Regan (2010) also found that the term practice readiness lacked clarity and was understood differently by nurses in practice, education and the regulatory sector. Such nebulous nature of practice readiness as a finding that emerged in this PhD study is also consistent with the findings of other studies that were challenged to identify the attributes and characteristics that comprise

practice readiness (Caballero, Walker & Fuller-Tsyzkiewicz 2011; Casner-Lotto & Barrington 2006).

Practice readiness, also referred to as work readiness, relates to the extent that graduates are perceived to have the necessary knowledge, skills, attitudes and attributes to prepare them for the work environment (AC Nielsen 2000; Caballero, Walker & Fuller-Tsyzkiewicz 2011). The AC Nielsen survey of employer satisfaction with graduate skills revealed that Australian employers, across various disciplines and fields, value a range of personal qualities that lie outside the realm of academic achievements such as personal presentation, motivation, problem solving, enthusiasm and ambition (AC Nielsen 2000).

Similarly in the USA, Casner-Lotto and Barrington (2006) in their report '*Are They Really Ready To Work? Employers' Perspectives on the Basic Knowledge and Applied Skills of New Entrants to the 21st Century U.S. Workforce*' expose the prevalence of a lack of clarity regarding what is meant by work readiness. The "Are They Really Ready to Work" report suggests there to be a lack of consensus regarding the general skills and attributes that embody work readiness. As such, it has been widely acknowledged that work readiness is difficult to assess as a criterion for employment given its nebulous nature and the lack of clarity and consensus regarding its attributes (Caballero, Walker & Fuller-Tsyzkiewicz 2011; Gardner & Liu 1997; Walker et al. 2013). Despite the asserted difficulty in defining what practice readiness actually means, Caballero, Walker and Fuller-Tsyzkiewicz (2011) have recently highlighted a growing desire by stakeholders in Australia to effectively and systematically assess graduate work readiness. To address this issue, Caballero, Walker and Fuller-Tsyzkiewicz (2011) conducted a

qualitative study aiming to identify the characteristics and attributes that comprise work readiness and develop a scale to assess graduate work readiness across a range of disciplines. The development of this graduate work readiness scale involved a total of thirty participants, nine of whom were human resource professionals with experience in graduate recruitment and twenty-one were new graduates employed in transition programmes across a range of disciplines (Caballero, Walker & Fuller-Tsyzkiewicz 2011). The results of their inquiry revealed that work readiness is a multidimensional construct and that ‘organisational acumen’ as well as social intelligence, work competence and personal characteristics are all attributes that contribute to graduate work readiness (Caballero, Walker & Fuller-Tsyzkiewicz 2011, p. 47).

The significance of the substantive theory that emerged, namely, ***Practice Readiness: A Nebulous Construct*** is that it offers an explanation of how practice readiness, as it relates to newly graduated RNs in the Australian context, is viewed. This is a result of NUMs and BNPCs **Inhabiting Disparate Realities**.

Discussion on how the core category and the three categories engage with existing literature will now follow. The discussion will commence with dialogue on the core category **Inhabiting Disparate Realities**.

Inhabiting Disparate Realities

The core category must be central to the data and must relate to most other categories (Glaser 1978; Gibson & Hartman 2014; Urquhart 2013). In this study, the core category **Inhabiting Disparate Realities** was central to the data and

provided a link between all three categories and their associated sub-categories. The discussion that follows depicts the different epistemological positions of participants, which informed **Inhabiting Disparate Realities** and demonstrates its relationship to all other categories and sub-categories.

Inhabiting Disparate Realities refer to the social architecture regarding the worlds in which NUMS and BNPCs inhabit. **Inhabiting Disparate Realities** fundamentally means that NUMs and BNPCs, as a result of varying **system drivers**, view graduate RN practice readiness through different lenses. Despite the fact that both participant cohorts acknowledged that **professional** and **contextual enculturation** contribute to graduate practice readiness, participants' opinions differed as to the focus and timing of when graduate RNs should attain **professional** and **contextual enculturation**. It is this divergence in opinion, as a result of varying **system drivers** that shaped participants' perspectives. As such, their priorities and expectations regarding graduate RN practice readiness were inevitably going to be different. Whilst acknowledging the fact that newly graduated RNs are indeed novices, they were also expected to **hit the floor running** as they commenced employment. **Inhabiting Disparate Realities** therefore, is a multifarious interplay of numerous features that in turn contribute to varied understandings of what it means to be practice ready.

The conceptualisation of this substantive theory and core category was enhanced by applying the three basic premises outlined below that underpin symbolic interactionism as a practical theoretical framework to explain it:

The first premise is that human beings act towards things on the basis of the meanings that the things have for them. ... The second premise is that the meaning of such things is derived from, or arises out of, the social

interaction that one has with one's fellows. The third premise is that these meanings are handled in, and modified through, an interpretive process used by the person in dealing with the things he encounters.
(Blumer 1969, p. 2)

In an effort to further explain symbolic interactionism, Charon (2010, p. 2) states that:

People interact over a period of time; out of that interaction they come to share a perspective; what they see will be interpreted through that perspective; often each perspective tells us something very different about what is really true.

Charon (2010, p. 4) asserts that 'human beings always see reality through perspectives'. Given that each perspective represents only an angle on reality, each person therefore, can only see part(s) of the reality. Charon (2010, p. 8) adds that 'a perspective, then, by its very nature, is a bias; it contains assumptions, value judgments ... as a result, it influences our action in the world'. As such, a phenomenon cannot simply be understood from only one perspective and that many perspectives can and should be used, as each perspective might tell us something important about that phenomenon (Charon 2010).

In this study, the ontological assumptions behind symbolic interactionism recognise that participants are influenced by **Inhabiting Disparate Realities**. This is important to note, as this impacts the participants' understanding regarding newly graduated RN practice readiness and therefore, impacts their expectations of graduate RNs. As such, NUMs and BNPCs fundamentally viewed the notion of practice readiness from different angles, through different lenses and they had different ideas about what they thought graduate RNs should be able to do and when they should be able to do it. This explains how participants' varying

perspectives have allowed them to only see their part of reality; that is, the reality, which is driven by their own expectations and priorities in relation to graduate RN practice readiness.

Charon (2010) further explains that people usually believe that their perspective is the right one and that they often reject other perspectives that they do not know much about. A perceived lack of meaningful collaboration and authentic partnership between education and practice sectors as claimed by participants in this study, may have contributed to a limited understanding of each other's realities and as such, each other's perspectives. According to Gassner et al. (1999 p. 17), collaboration is more than just working together, 'it is a process of shared learning between two nursing cultures; academia and clinical'. Broadbent (2011) further asserts that when two nursing cultures work together, collegiate presence is required. Is the cause of **Inhabiting Disparate Realities** in the case of NUMs and BNPCs a result of a lack of meaningful collaboration and authentic partnership between faculty at universities and clinicians at health services as claimed by participants in this study? And, has this inadequate collegiate presence (Broadbent, 2011) in each other's world contributed to a lack of understanding of each other's realities and as such, each other's perspectives?

Other studies also found the lack of meaningful collaboration and authentic partnership between education and practice sectors to be one of the factors that contribute to the lack of graduate practice readiness (Newton & McKenna 2007). Wolff, Pesut and Regan (2010, p. 189) proclaim that 'mutual accountability between the practice and education sector needed to be re-established'.

In Australia, universities are required to show evidence of wide stakeholder consultation with regard to BN programme development and structure. The BN programme accreditation process is underpinned by the current *Registered Nurse Accreditation Standards* (ANMAC 2012, p. 9), which requires the curriculum to be ‘developed in collaboration with key stakeholders reflecting contemporary trends in nursing and education’. Collaborative approaches are important as it is widely acknowledged that the quality of the partnership between education and practice sectors significantly impacts clinical education and the learning experiences of undergraduate nursing students (Bernal, Shellman & Reid 2004; Buchan, O'May, & Little 2008; Clare et al. 2003; Dapremont & Lee 2013; Glazer et al. 2011; Holland & Lauder 2012; MacPhee 2009; Keogh et al. 2010; Tuohy 2011; Usher et al. 2015; Wotton & Gonda 2004). According to Holland and Lauder (2012 p. 63),

pre-registration midwifery and nursing programmes are delivered in both education and service areas; responsibility for this must be an equal one between those who work in Higher Education and Health Service and finding a way to deliver collaborative evidence-based education and practice environments which are led by effective clinical and educational leaders as well as practice educators, supervisors and assessors with both the clinical knowledge and skills, plus those related to their educational role, is essential.

In New Zealand, a national review of undergraduate nursing education undertaken in 2001 recommended that the responsibility for undergraduate nursing education be shared between academic and practice sectors through formalising working partnerships (Buchan, O'May, & Little 2008; Keogh et al. 2010; Tuohy 2011). Similarly in the USA, practice-academic partnerships were endorsed by the American Association of Colleges of Nursing in the 1990s as being critical to

achieving quality education, practice and research (Bernal, Shellman & Reid 2004; MacPhee 2009; Tuohy 2011).

In this study, 'working together' was raised by participants despite the presence of various formal and informal practice-academic partnerships in Australia. Some participants thought that universities already go through a process to engage healthcare services in consultation as required by the accreditation standards

Despite a desire or requirement to engage, NUMs and BNPC participants described what they perceived as a lack of meaningful collaboration and authentic partnership. Participants talked about collaboration but many felt it was not as meaningful as it could be and different stakeholders have their own set agendas.

The perceived lack of meaningful collaboration and authentic partnership between the education and practice sectors in this study underpins the core category **Inhabiting Disparate Realities**. How can views about practice readiness be shared when there appears to be a lack of meaningful collaboration and authentic partnership? Given that worldviews and realities are divergent as this research found, a strategy to overcome this is forming meaningful and authentic partnerships. A collaboration that acknowledges the notion that preparing graduate RNs should be a shared responsibility between the education and practice sectors and the regulatory bodies in Australia (ANMAC 2012; Benner 2012; Henderson, Heel & Twentyman 2007; ICN 2009; Mannix, Wilkes & Luck 2009; Turner et al. 2006; Usher et al. 2015; Watson, M 2006).

Findings from this current study are congruent with the findings of a Canadian qualitative study, which aimed to explore the perspectives of 150 nurses in

practice, education and the regulatory sector regarding the practice readiness of graduate RNs (Wolff, Pesut & Regan 2010). According to Wolff, Pesut and Regan (2010, p. 190), ‘with the movement away from the shared accountabilities between the education and practice sectors, it is no longer clear who plays what role in ensuring that nurses are practice ready’. How can shared preparation occur if we don’t collaborate in a meaningful way?

The ambiguity regarding whose responsibility it is to educate nurses was reflected by the views of participants in this study. Participants suggested there is a perception in the health industry that preparing graduate RNs has become the responsibility of universities alone rather than it being shared by both the education and practice sectors. The importance of engaging in strong working relationships between the education and practice sectors to better prepare the future nursing workforce has been widely acknowledged nationally and internationally, both recently and indeed over the last few decades (Clare et al. 1996; Clare et al. 2003; Dapremont & Lee 2013; Davies, Turner & Osborne 1999; Granger et al. 2012; Häggman-Laitila & Rekola 2014; Henderson, Heel & Twentyman 2007; Holland & Lauder 2012; Jeffries et al. 2013; Kilstoff & Rochester 2004; Mannix, Wilkes & Luck 2009; Turner et al. 2006; Usher et al. 2015). Indeed, participants in this current study asserted that working together is essential to preparing practice ready graduates.

Given that BN programmes are delivered in both academic and clinical environments, the responsibility for such programmes ‘must be an equal one’ between those who work in the practice and education sectors (Holland & Lauder 2012, p. 63). It would appear though, that since the *en masse* transfer of nursing

education to the tertiary sector in Australia in the mid 1980s, a difference in opinion regarding the responsibility for preparing graduate RNs has emerged. This delineation of responsibility might have contributed to what is perceived to be a lack of meaningful collaboration and authentic partnership between the education and practice sectors in relation to the education of RNs.

The delineation of responsibility has been long debated following the transfer of nursing education to the tertiary sector (Clare et al. 1996; Gassner et al. 1999; Mannix, Wilkes & Luck 2009; Turner et al. 2006; Usher et al. 2015). Clare et al. (1996, p. 170) noted that ‘since the transfer of nursing education to the tertiary sector, education and beginning practice have become separate entities with little continuity’. Gassner et al. (1999, p. 15) argued that even though universities have to collaborate with health services to secure opportunities for clinical placements, ‘often this is one-way liaison with the university controlling all phases of the collaboration’. Kilstoff and Rochester (2004) further highlighted this issue and suggested that the onus is on both the health and academic sectors to work together to better understand the transition process of graduate RNs and to put strategies in place to support them. In fact, the recent proposal by the *Australian College of Nursing*, which is a key national professional nursing organisation, to form a national transition support framework to enhance the support for newly graduated RNs, highlights the significance of this issue and the need to do things differently (Thoms 2014). However, for this framework to be effective, El Haddad (2014, p. 33) suggested that:

... its architects first need to consider defining the graduate identity, to ensure that clinicians, employers and educators’ expectations of graduate RNs remain reasonable and realistic. Furthermore, this

framework needs to work towards diminishing the delineation of educational responsibilities, in which the education sector is mainly responsible for the pre-registration component and the health sector takes over for the post-registration component, which includes the transition of new graduates into the nursing workforce.

This concludes the discussion on the core category **Inhabiting Disparate Realities** and its engagement with literature. This exploration indicated that NUMs and BNPCs, as a result of varying **system drivers**, view graduate RN practice readiness through different lenses. Consultation between the education and practice sectors appeared to lack meaning and authenticity, which underpins the core category **Inhabiting Disparate Realities**.

Each category and their associated sub-categories will now be discussed. Existing literature will again be drawn upon to elucidate the findings. The discussion commences with the category **system drivers** and its associated sub-categories.

System Drivers

NUMs and BNPCs appear to be constrained by varying **system drivers** that contribute to them **Inhabiting Disparate Realities**. In this study, **system drivers** relate to monetary and regulatory processes and standards that govern both the practice and education sectors at macro level i.e. curricula composition/requirements and accreditation standards (ANMAC 2012; NMBA 2006, 2016) and at micro level i.e. skill-mix at unit/ward level and budget requirements. In this study, **system drivers** were identified as **curricula**, **skill-mix**, and **fiscal constraints**. These **system drivers** led to participants having dissimilar perspectives that in turn influenced their expectations and priorities

regarding newly graduated RN practice readiness in contrasting ways. This lack of congruence is explicated in the following discussion.

Curricula

The findings demonstrate how certain features of the BN curricula in Australia impact graduate RNs' preparation and hence their practice readiness. The most significant of these features, which will be referred to as elements, include: the broad nature of the curricula and its inconsistent theoretical and practical components; the perceived limited hours of clinical exposure; and the lack of consistency in student supervision and assessment of clinical competence. Emergent features of the BN curricula in Australia contributed to participants having different **system drivers**. Such **system drivers** in turn, influenced their perspectives and contributed to their disparate realities.

In the mid 1980s, nursing education in Australia transferred from an apprenticeship model, which was driven by the needs of health services (Russell 1990; Sellers & Deans 1999) to a model situated in the tertiary education sector and one that became driven by the education needs of students as determined by set curricula and university demands (Fetherstonhaugh, Nay & Heather 2008). Since then, two major national inquiries into nursing education (Heath et al. 2002; Reid 1994) have endorsed this transfer in Australia. Both inquiries highlight the challenges encountered by all stakeholders involved in nursing education, given the rapid transformation and complexity of the healthcare system (Senate Community Affairs Reference Committee 2002). Offering comprehensive nursing

education, also referred to as “generalist” nursing education, to prepare graduate RNs with broad based clinical knowledge and skills able to practice in a broad range of healthcare settings, was one of the recommendations of the *National Review of Nursing Education 2002: Our Duty of Care Report* (Heath et al. 2002). At the time, the Senate Community Affairs Reference Committee (2002, p. 82) did not recommend a standard national curriculum but one that allows for local variation:

That the Australian Nursing Council, in conjunction with key stakeholders, including State regulatory bodies, the universities, professional nursing bodies and nursing unions, develop a national curriculum framework or guidelines for undergraduate nursing courses to ensure greater consistency in the interpretation of the ANCI competencies.

To provide national consistency, Australian nurse leaders settled on two interventions, one was the establishment of the bachelor degree as the minimum qualification for registered nurses (ANMC 2009), the other was applying specific outcome measures in the form of national competency standards (Grealish & Smale 2011). Since then, nurse academics have been tasked to ensure nursing curricula remain relevant to clinical practice requirements through stakeholder consultations (ANMAC 2012).

In the last ten years, significant changes have taken place with regard to the regulatory environment in Australia. The Productivity Commission (2005) report titled *Health Workforce Review*, submitted to the Council of Australian Governments (COAG), recommended that a single national registration board be established to bring national consistency in the areas of registration of healthcare professionals and accreditation of health curricula. Based on the recommendations

of this report, the National Registration and Accreditation Scheme (NRAS) was ratified in 2008 (COAG 2008). Prior to this date, each state and territory in Australia had its own registration board with its own standards. Nurses could only register in one place and had to seek new registration if they moved inter-state.

In 2010, and under the NRAS, the Australian Nursing and Midwifery Council (ANMC) was appointed as the national accreditation authority for programmes leading to registration and endorsement. To reflect its new function as the national accrediting authority for nursing and midwifery education programmes, the ANMC changed its name to the Australian Nursing and Midwifery Accreditation Council and reviewed the *Registered Nurse Accreditation Standards* (ANMAC 2012). These current standards expect universities:

... to ensure graduates have the required common and transferable skills, knowledge, behaviours and attitudes (articulated in the National Competency Standards for the Registered Nurse) upon which to build the competencies they need to practice.
(ANMAC 2012, p. 8)

At the time it was formed in 2010, the Nursing and Midwifery Board of Australia (NMBA) adopted the ANMC *National Competency Standards for the Registered Nurse* (NMBA 2006).

Despite the specific measures to enhance consistency regarding nursing education through the national accreditation standards in Australia, inconsistencies in Australian BN curricula persist (Ralph et al. In Press). Such inconsistencies contribute to the variable nature of student learning (Walker 2005) and concomitantly to variations in graduate attributes (McAllister 2001).

Variations are to be expected given that Australian universities are required to adhere to the *National Competency Standards for the Registered Nurse*, which are very broad, when developing their BN curricula (ANMAC 2012; NMBA 2006). These standards propose that graduate RNs should be able to provide ‘care in a range of settings that may include acute, community, residential and extended care settings, homes, educational institutions or other work settings’ on entry to practice (NMBA 2006, p. 2). The expectation that newly graduated RNs should be able to aptly work in any practice setting in any jurisdiction, means that their educational preparation needs to be broad. As such, the broad and inconsistent theoretical and practical components of the Australian BN curricula are a product of the above regulatory standards (ANMAC 2012; NMBA 2006), which require the BN curricula to:

1. be responsive to changes in healthcare delivery models
2. deliver comprehensive nursing education to prepare a generalist RN capable of working in any nursing context.

This is significant and impacts upon acute care practice readiness; the very setting where the majority of graduates continue to be initially employed (Duchscher 2009; North, Leung & Lee 2014; Olson 2009). Such trends in graduate RN employment appear to endure despite the increased focus on primary healthcare service provision in Australia and globally. This trend was illustrated by participants in this study.

Some of the factors that informed these regulatory standards (ANMAC 2012; NMBA 2006) and instigated the delivery of such broad and inconsistent

theoretical and practical components of the Australian BN curricula are discussed next.

The broad and inconsistent nature of the curricula

A radical shift in healthcare delivery from acute to primary healthcare settings was called for by the *World Health Organization Alma-Ata Declaration* (WHO 1978). This was in response to the sharp global increase in prevalence of chronic diseases and the complex care needs of aging global populations (WHO 2008). Indeed, a shift like this in healthcare delivery does not only affect clinical jurisdictions, but it also impacts upon nursing education nationally and internationally leading to curricula changes to address primary healthcare skills and competencies (Andre & Barnes 2010; Betony 2012; Rich & Nugent 2010; Salminen et al. 2010).

The changing landscape of healthcare delivery in Australia led to a focus on strengthening the role of primary healthcare nurses as a strategy for healthcare reforms (Aged & Community Services Australia 2010; Department of Health and Aging 2009b; Halcomb et al. 2014; Productivity Commission 2011). Given the prevalence of chronic diseases and the complex care needs of an aging Australian population, policy makers were challenged to consider optimal strategies that enable the provision of high quality healthcare that is also cost effective (Productivity Commission 2011; Treasury 2015a). Developing capacity in nursing graduates through education and clinical exposure to meet the future needs of this population in a range of clinical settings was one of the recommendations of the Productivity Commission (2011).

Indeed, to meet such a recommendation, BN curricula in Australia needed to be broad in nature and to offer wide clinical exposure in varying clinical contexts. This was acknowledged by participants in this study. All BN programmes offer off-campus clinical experience time, which is also referred to as clinical placement or work integrated learning. Clinical placements offer students opportunities to interact with real patients or clients and healthcare providers, thus enabling them to build their confidence and develop their professional identity. This is where students are expected to apply learned knowledge and skills in a real practice environment (Keleher, Moxham & Shakespeare 2007). It is widely acknowledged that optimising clinical placements is vital to enabling students to integrate theory into practice and build their confidence, which facilitates their transition from student to professional nurse (Broadbent et al. 2014; ICN 2009; Mannix, Wilkes & Luck 2009; Walker et al. 2012). Participants in this study also alluded to this.

However, the broad clinical exposure as a component of the 800 minimum hours of clinical experience does not appear to have met the intended outcomes in relation to developing capacity in nursing graduates across varied clinical settings in Australia. Despite most Australian universities exposing their undergraduate nursing students to primary healthcare settings (Bloomfield et al. 2015), Peters, McInnes and Halcomb (2015, p. 179) found that generally, such exposure 'does not adequately address the fundamental principles of primary health care nursing'. Similarly, Happell and McAllister (2014) highlight the inadequate preparation of nursing graduates for mental health practice even though mental health has been listed as one of the national health priorities in Australia since 1996 (AIHW

2015). Barriers to quality mental health learning were identified as overcrowded curricula (Happell & McAllister 2014) and insufficient numbers of clinical placements in designated mental health settings (Moxham et al. 2011).

Interestingly, the need to promote comprehensive or “generalist” nursing education, as a **system driver**, appears contradictory to the now deeply specialised nature of nursing practice. The principle of privileging the breadth rather than the depth of knowledge in nursing education was challenged by a Canadian study (Romyn et al. 2009). Romyn et al. (2009) questioned whether “generalist” nursing education can equip students with the knowledge and skills required to function effectively in all practice settings as they join the nursing workforce.

Dissatisfaction with the ability of such comprehensive nursing education to prepare graduate RNs for the reality of clinical practice is widely noted at a national level. An example is the argument put forward by Happell and McAllister (2014, p. 330), who assert that ‘nursing and its specialties continue to grow and become more focused in scope’. Like Peters, McInnes and Halcomb (2015) who suggest primary health care is largely silent in Australian BN curricula, other authors suggest that despite the specialty of mental health being listed as a national health priority (AIHW 2015), the current model of nursing education in Australia does not offer students adequate preparation for mental health nursing practice (Happell & McAllister 2014; Moxham et al. 2011). Happell and McAllister (2014, p. 335) question the product of such comprehensive nursing education and recommend that ...

Students of nursing may need to be given specialty options in their undergraduate degree and thus be able to achieve clear competence in a specific designated practice area, such as mental health nursing. Consideration for a new model of undergraduate nursing education in Australia appears long overdue and should be undertaken as a matter of priority.

The need for specialty clinical acumen not being met by a broad BN curriculum is also described by Ramritu and Barnard (2001) who argued that the model of nursing education in Australia does not offer students adequate preparation for paediatric settings. They recommend that universities consider a fourth year internship programme to address such deficiencies (Ramritu & Barnard 2001). Interestingly, such strategy was also recommended by participants in this study to supplement the clinical exposure of undergraduate nursing students.

Variations in the arrangements between universities and practice providers in Australia regarding the required clinical placements are longstanding. Walker (2005) discussed such variation, which includes differences in the hours or days students spend in each clinical context; differences in the acuity of clinical context and differences in the type of supervision and support afforded to students. Given that students' clinical experiences are impacted by such variations, Walker (2005, p. 38) concluded that 'the product of our nursing curricula in Australia, a newly registered nurse, is not as homogeneous as one might expect or hope'. In this study, participants discussed just how varied clinical placements can be.

Making decisions and prioritising the theoretical and clinical components that best inform BN curricula is considerably challenging for universities for several reasons. These include the limited availability of quality placement opportunities as a result of a substantial increase in nursing student enrolments, staff turnover

and resource shortages (CDNM 2005; HWA 2012b, 2014). The limited availability of quality placement opportunities has been recognised as one of the major constraining factors to the expansion of the nursing workforce nationally and internationally (Barnett et al. 2012; Dobrowolska et al. 2015; HWA 2012b; Lamont, Brunero & Woods 2015; McCutcheon et al. 2014; PhillipsKPA 2008; Smith, Corso & Cobb 2010). BNPC participants in this study reflected on the difficulties they face in accessing quality placements for their students.

In the UK, Drennan et al. (2004) claim that the limited availability of quality placement opportunities and the requirement for students to gain a wide range of clinical exposure meant that short observational placements were taking precedence over longer placements. This trend also occurs in Australia where current BN curricula offer students varied clinical placement opportunities for short periods of time in wide variety of clinical settings (Fetherstonhaugh, Nay & Heather 2008).

Participants in this study acknowledged the need for students to have wide clinical exposure to meet the ANMAC requirements but they recognised that offering students short clinical placements is not optimal for learning. Indeed, participants were critical of short placements and discussed the value of students developing relationships with clinicians by returning to the same clinical environment.

Such participants' sentiment regarding shorter placements is consistent with the findings of earlier studies (Clare et al. 2002; Rydon, Rolleston & Mackie 2008; Walker 2005). A curriculum review conducted by an Australian university more than a decade ago, examined some of the limiting factors on the quality of clinical placements (Clare et al. 2002). This review determined that the length of clinical placement was considered too short to establish meaningful relationships between

staff and students and recommended considerations for longer and more in-depth placements (Clare et al. 2002).

In a discussion paper on a successful Australian practice-education partnership, Walker (2005) highlights the value of enabling students to develop familiarity with one clinical context rather than being rotated repeatedly for the purpose of gaining a wide range of clinical exposure. Furthermore, Walker (2005) argues that while undertaking a clinical placement, students are generally concerned with developing generic and specialist clinical skills and knowledge, which is best achieved by keeping the students in the same clinical environment for the whole semester. Such strategy enables students to ‘develop a deep familiarity with the context in which they are working which then enables them to relax ... and thereby concentrate on the development of skills and knowledge’ (Walker 2005, p. 38). Walker (2005, p. 38) challenges the notion that students greatly benefit from ‘sampling little bits of different areas so they can broaden their knowledge’ and warns about the cliché often applied to generalist nurses: ‘Jack of all trades and master of none’.

Mannix et al. (2006) argued that precious time is wasted as a result of offering multiple placements of shorter durations where students need to re-orientate themselves to the new clinical environment. Similarly, Nash, Lemcke and Sacre (2009) warned that frequent and short placements mean that students maintain observational mode, which impedes their learning. Other more recent studies also determined that undertaking short placements leaves students in observational mode and makes it very difficult for them to become familiar with the clinical

operations of the health service provider where they might eventually be employed (Fetherstonhaugh, Nay & Heather 2008; Wolff, Pesut & Regan 2010).

Levett-Jones and colleagues (2008) investigated the influence of the duration of clinical placements on nursing students' experience of belongingness. Their multi-site study was conducted at two Australian universities and one university in the United Kingdom. A mixed-method design was adopted where a survey (*Belongingness Scale – Clinical Placement Experience*) was completed by 362 nursing students, 18 of whom also took part in semi-structured interviews. Levett-Jones and colleagues (2008) found that students need a period of adjustment to settle in and become part of the team each time they move to a new clinical environment. In 2008, the research team proposed the need to urgently examine the structure of clinical placements offered by Australian universities to ensure their adequate duration (Levett-Jones et al. 2008).

Inconsistencies and variations in clinical hours and clinical context are not unique to Australian BN programmes (Betony 2012; Dobrowolska et al. 2015; Salminen et al. 2010). In a recent study aiming to compare the nature of nursing clinical education, Dobrowolska et al. (2015) affirm that variations exist in BN programmes in and amongst the eleven participating countries with regard to the length and context of clinical placements. Such variation is outlined in Table 4.

Table 4: Nursing clinical practice models in eleven countries
(Dobrowolska et al. 2015)

Country	Length of course in years	Length of course in hours	% of time & (hrs) in clinical placement	Clinical placement settings
Croatia	3	4600	50 (2300)	Hospital & community setting
Czech Republic	4	4600	50 (2300)	Hospital, community setting & social care sector
England	3	4600	50 (2300)	Hospital, community setting, general practice, public health & prison
Iceland	4	6000	30 (1800)	Hospital, community setting, primary care & primary schools
Ireland	4	4600	64 (2900)	Hospital, community setting & general practice
Italy	3	5400	30-40 (1800)	Hospital & community setting
Poland	3 or 3.5	4815	50 (2300)	Hospital & community setting
Serbia	3	4600	60 (2800)	Hospital, community setting, primary care & prevention departments
Slovenia	3	5400	44.4 (2400)	Hospital, community setting, primary care & social care sector
Spain	4	4600	33.3 (2400)	Hospital, community setting & primary care
USA	4	2400	41 (1000)	Hospital, community setting, primary care, prevention departments, social care, ambulatory care & veteran care

The need to offer comprehensive education to prepare nursing graduates who can aptly work in any practice setting and the difficulties in accessing quality placements are some of the factors that impact curricula design and contribute to variations in its theoretical component and the clinical hours and context offered by different universities. Such **system drivers** shape the reality of BNPCs and as such, inform their perspectives and priorities. NUM participants from the acute care setting, on the other hand, have different **system drivers**, again demonstrating their **Inhabiting Disparate Realities**.

Perceived limited hours of clinical exposure

The perceived limited hours of clinical exposure is another significant element of the BN curricula that contributes to participants having dissimilar **system drivers**.

As discussed earlier, the *Registered Nurse Accreditation Standards* are currently used by the Australian Nursing and Midwifery Accreditation Council (ANMAC 2012) to accredit all nursing programmes leading to registration. These standards require a ‘minimum of 800 hours of workplace experience, not inclusive of simulation activities, incorporated into the program and providing exposure to a variety of health-care settings’ (ANMAC 2012, p. 13). It is not documented how the 800 clinical hours were determined as a minimum requirement in the accreditation standards (Ralph et al. In press).

However, fiscal constraints and the limited availability of appropriate venues within the practice sector may have contributed to several more Australian

universities requiring only the minimum of 800 off-campus clinical training hours.

In the current study, some participants believed that students are not afforded adequate clinical time and highlighted the value of offering BN students more clinical hours than the minimum 800 hours required by ANMAC. The perception of participants in this study that students are not afforded adequate clinical time and exposure to prepare them for transition to practice is consistent with earlier national and international studies. Interestingly, the notion that students are not afforded adequate clinical exposure to prepare them for transition to practice was highlighted in 1997 (Madjar et al. 1997) and is still being deliberated some 19 years later. Several North American studies also reported that participants perceived clinical placement hours were not adequate and recommended that nursing students should be offered longer clinical experiences that reflect the reality of nursing during their academic preparation (Del Bueno 2005; Hickey 2009). Hoffart, Waddell and Young (2011, p. 340) conducted a literature review on graduate RN transition experiences, and found that ‘the most frequently noted academic characteristic new graduates perceived as important to their transition success was the amount of their clinical experience as students’.

In a more recent scoping study, Buchanan, Jenkins and Scott (2014, pp. 46-48) from the University of Sydney outline the characteristics of clinical placement of several health disciplines. The differences in clinical hours students of each discipline are required to complete is quite vast. BN programmes in Australia have less clinical hours than most other undergraduate health disciplines as outlined in Table 5.

Table 5: Characteristics of clinical placements of a sample of health disciplines at the University of Sydney (adapted from Buchanan, Jenkins & Scott 2014)

Characteristics of clinical placement	
Medicine	Students are enrolled in one of seven clinical schools and undertake their training. Highly embedded from the beginnings of their four year postgraduate degree, medical students spend the entirety of their final two years undertaking clinical placement rotations with a team of practitioners. Students graduate able to seek provisional registration from the Australian Medical Council, however must complete an internship year from registration, and significantly more years of training to qualify as a consultant who is able to practice relatively autonomously.
Nursing	Nursing has developed from a model of 'teaching by the bedside'. Students graduate having completed the competencies and in excess of the 800 hours required for the Nursing and Midwifery Board of Australia. Nurses are considered ready to practice immediately post-graduation, although clinical competencies are developed across the degree as clinical placement hours increase. The completion of a transition-to-practice year is not required for registration, but many employers organise a transition program to enhance workplace orientation and socialisation.
Social Work	Students at the University of Sydney can study social work as part of either an undergraduate or a Master degree, and placement length and requirements are the same for both degrees. Placements are required to be for 1,000 hours , and this is typically completed with one 60 day placement followed by one 80 day placement. Social Work is not registered by AHPRA, but the Australian Association of Social Workers is responsible for accreditation of practitioners. The University does employ a Social Worker to provide supervision when one is not otherwise available in the workplace.
Physiotherapy	Students can study physiotherapy as part of an undergraduate or a Master degree at the University of Sydney, undertaking a total of 880 or 700 hours respectively. Masters students undertake placements early in their degree, whilst undergraduate students undertake substantive placements only once they've completed their first and second years. Private practitioners acknowledge students are largely able to provide billable services whilst on their placements, especially at the later stages of their training. All students graduate eligible for registration with the NSW Physiotherapists Registration Board. Placements are highly difficult to obtain, given the large and increasing number of Universities that provide this degree.
Occupational therapy	Students in both undergraduate and Master degree programs are required to undertake a minimum of 1,000 hours of placement in a diverse array of settings, reflecting the diversity of employment of occupational therapists. In occupational therapy, students are allowed to undertake "Role Emerging" placements, in which the students do not have to be working in a work site with another occupational therapist employed, however still require the input of a qualified occupational therapist in a supervisory capacity for at least a portion of the placement. These placements involve students directly offering services. Occupational therapists are registered with AHPRA, and Occupational Therapy Australia is delegated with undertaking accreditation on behalf of the Occupational Therapy Board. Placements are highly competitive.

Although Australian nurse leaders fought for a four-year degree programme, the federal government only agreed to fund a three-year programme granting a Bachelor of Nursing degree (Kenny et al. 2004; Williams et al. 2000). Summarising the state of affairs, Andre and Barnes (2010, p. 259) conclude that...

unlike many other health professional programs, which have a minimum of 4 years of university education followed by a compulsory 1-year internship, nursing in Australia is a 3-year bachelor level degree, and has no compulsory intern year, though most graduating nurses enrol in employer supported transition programs.

Australian nurse leaders continue to deliberate over this issue and discourse remains robust and complex whether the BN degree should be a three or four year programme (El Haddad, Moxham & Broadbent 2013; Kenny et al. 2004). It is noteworthy to mention, that Canadian nurse leaders are also challenged by the issue of graduate practice readiness even though Canada requires a four-year degree to practice nursing (Wolff, Pesut & Regan 2010).

In this study, participants' mixed views regarding the length of clinical exposure afforded to undergraduate nursing students appear to reflect the views of the wider community of Australian nurse leaders. Some participants believe that the focus should be on the quality not quantity of clinical exposure. However, the majority of participants appear to share the view that more clinical exposure is warranted to enhance the work readiness of graduate RNs. Despite the fact that this research did not set out to explore solutions, as alluded to in *Chapter Four*, participants offered different strategies in relation to the BN curricula, they believed would enhance graduate RN practice readiness. These strategies include:

- having a four-year rather than a three-year BN programme,

- adding a one-year internship where students get paid for the fourth year,
- offering provisional registration after completing the three-year programme, where graduates work under supervision while being remunerated,
- offering more simulation in undergraduate nursing education and paid student employment in healthcare to further develop students' fundamental clinical skills as an adjunct to clinical placement.

Strategies to further develop students' fundamental clinical skills as an adjunct to clinical placement are elucidated further in this section commencing with discussion on simulation in undergraduate nursing education.

Given the growing recognition of the insufficient clinical placement opportunities in response to the increasing number of undergraduate nursing students (CDNM 2005; HWA 2012b, 2014), simulation-based education is increasingly being utilised as a strategy to help bridge the theory-practice gap (Hayden et al. 2014). How simulation could be more greatly utilised to better prepare students, was raised by participants in this study.

The concept of simulation in nursing education is not new (Nehring 2010) but the use of high-fidelity simulation has increased considerably in the last fifteen years (Hayden, Smiley & Gross 2014). In an evidence-based inventory of teaching approaches, Crookes, Crookes & Walsh (2013) found that educators consider the use of simulation to be an effective tool for making theoretical nursing content meaningful and contextually engaging.

The use of simulation is widely acknowledged to provide controlled teaching and learning opportunities for nursing students that they may not have otherwise in a real clinical environment (Cooper et al. 2015; Hayden, Smiley & Gross 2014; Hope, Garside & Prescott 2011; Jeffries 2005; McCallum 2007; Reid-Searl et al. 2014; Rush et al. 2010; Traynor et al. 2010). This is significant given the ongoing debate regarding the theory-practice gap in nursing and the challenges in accessing clinical placements (Hayden, Smiley & Gross 2014; Hope, Garside & Prescott 2011).

Engaging in simulation-based learning in a safe environment is reported to build learners' self-confidence (Arnold et al. 2013; Berragan 2014; Thidemann & Soderhamn 2013; Traynor et al. 2010), build their reflective and critical thinking skills (Thidemann & Soderhamn 2013), enhance exposure to 'breaking bad news' (Ramm, Thomson, Jackson 2015, p. 826), and positively impact students' self-efficacy and learning motivation (Oh, Jeon & Koh 2015). Flood and Robinia (2014, p. 329) suggest that nurse educators should ideally 'coordinate efforts to transition students' learning from the classroom, into hands-on practice in simulation laboratories, and then implementation in clinical settings'. But, they add that the ideal is often not achieved due to multiple challenges (Flood & Robinia 2014).

Laschinger et al. (2008) warn that simulation in undergraduate nursing education should not be considered as a replacement but an adjunct to clinical practice. Furthermore, Hope, Garside and Prescott (2011) argue that simulation is not a stand-alone learning strategy, but a complimentary process that helps build the

learners' confidence and supports the application of the theory into practice. This was a viewpoint expressed by participants in this study.

Simulation takes place in clinical laboratories prior to visiting the clinical practice environment (HWA 2014). In Australia, the *Registered Nurse Accreditation Standards* (ANMAC 2012) stipulate that simulation activities are not included in the minimum 800 hours of clinical placement time. This is not the case in the UK. The inclusion of an optional 300 hours of simulated practice, as part of the 2300 practice hours within preregistration curricula, was endorsed by the Nursing and Midwifery Council (2007). Nevertheless, the remaining 2000 hours is still far in excess of the 800 hours of the Australian BN requirement. In a critical review of the literature on factors contributing to graduate practice readiness, Monaghan (2015) called for more research on the impact of simulation training to equip regulatory bodies with the necessary evidence to determine whether its use should be mandated across all programmes in the UK. In the USA, nurse regulators are discussing the issue of partially substituting clinical placement hours with simulation in light of the recent NCSBN national simulation study findings and the difficulties in attaining adequate clinical placements (Hayden, Smiley & Gross 2014).

Paid employment for students in healthcare was another strategy recommended by participants in this study to further develop their fundamental clinical skills as an adjunct to clinical placement hours. In addition to providing additional further clinical exposure to supplement the minimum prescribed clinical hours, paid employment of students was also perceived to facilitate familiarity within a

clinical context to enable **contextual enculturation**, which will be elucidated further in another section of this chapter.

This is interesting because nursing students were paid under the apprenticeship model, while they currently have to complete their prescribed clinical hours in a supernumerary unpaid capacity (Heath et al. 2002). The notion of paid part time employment for nursing students in health settings has gained popularity nationally and internationally in the last decade (Kenny et al. 2012). This is driven by concerns for student poverty and by the suggestion that such employment opportunities improve the knowledge and skills of graduates, hence optimising their practice readiness (Curtis & Williams 2002; Hickey 2009; Hoffart et al. 2006; Kenny et al. 2012; Phillips et al. 2012b; Rydon, Rolleston & Mackie 2008). Nursing student part time employment was advocated by the Australian *Senate Community Affairs Reference Committee* (2002, p. 61), who recommended that ‘hospitals and other healthcare agencies be encouraged to provide part-time paid employment for student nurses from the second year of undergraduate courses’.

Grealish and Smale (2011) argue that the supernumerary status of students implemented since the transfer of nursing education to the tertiary sector has led to the assumption that working and learning are separate undertakings. They add that current clinical placement approaches, ‘where students arrive in the field armed with ‘learning objectives’ only to have these dismissed by busy nurses who do not have time to ‘teach’ are no longer effective (Grealish & Smale 2011, p. 61). In light of this, Grealish and Smale (2011) suggest that new approaches to clinical placement should be considered where students are involved in nursing work as members of the team and engaged in context specific learning.

The above discussion illustrates how decisions regarding BN curricula and clinical placements are not always driven by best research evidence but also by **system drivers** that shape participants' priorities and perspectives.

This concludes the discussion on the perceived limited hours of clinical exposure as a significant element of the BN curricula that contributes to participants having dissimilar **system drivers** and **Inhabiting Disparate Realities**.

Student supervision and assessment of clinical competence

The last element of the Australian BN curricula perceived by participants to impact graduate RN preparation and practice readiness is the lack of consistency in student supervision and assessment of clinical competence. This finding is congruent with findings of other national and international studies in that, the nature of assessment of competence in practice is characterised as challenging and inconsistent despite the significant role it plays in safeguarding the profession (Bray & Nettleton 2007; Dolan 2003; Duffy 2004a; Franklin & Melville 2015; Helminen, Tossavainen & Turunen 2014; McGrath et al. 2006; Ossenberg & Henderson 2015; Vinales 2015a; Wells & McLoughlin 2014; Zasadny & Bull 2015). Factors contributing to such perceived inconsistencies include: heavy workload; staffing shortages and skill-mix; lack of training in the supervision and assessment processes; varying requirements and competency assessment tools (Tuohy 2011); and lack of understanding of students' learning objectives (Franklin & Melville 2015).

During clinical placements, nursing students are usually supervised and assessed by experienced clinicians in the role of preceptor, mentor or clinical facilitator. The preceptor or mentor is expected to enhance students' experiential learning, to act as a nurturer and a professional role model and also to provide opportunities for debriefing and reflection on practice (Altmann 2006; HWA 2014). In addition, the clinical facilitator acts as an assessor and a supervisor (HWA 2014). When clinicians are thrust into the clinical teaching role, many feel underprepared for what is expected of them (Anderson 2009; de Fulvio, Stichler & Gallo 2015; Forbes, Hickey & White 2010; McCarthy & Murphy 2008). Upskilling and supporting clinicians in their teaching role is necessary to enable them to better link students' practice experiences with the theoretical component of concurrent academic courses (Brammer 2008; Bray & Nettleton 2007; Davidson & Rourke 2012; de Fulvio, Stichler & Gallo 2015; Duffy 2004a, 2004b; Flood & Robinia 2014; Forbes, Hickey & White 2010; McCarthy & Murphy 2008). This was raised by participants in this study who argued that appropriate training and ongoing support for clinical assessors is warranted.

Failing students is fairly challenging for preceptors or mentors in practice (Duffy 2004a; Gainsbury 2010; Helminen, Tossavainen & Turunen 2014; McGrath et al. 2006; Vinales 2015a). Duffy's (2004a) important study in the UK on 'Failing to Fail Students' exposed the factors that influence the decisions of preceptors/mentors and the challenges they face in relation to failing underperforming students. According to Duffy (2004a), these factors include:

- a lack of confidence in own ability to teach and assess student performance;

- insufficient time dedicated to clinical teaching and assessment in a busy clinical environment;
- the wish to give a student the ‘benefit of the doubt’ especially in the early stages of their clinical experience; and
- a lack of motivation on the part of preceptors/mentors.

In accordance with Duffy’s (2004a) findings, participants in this study expressed similar concerns regarding assessors failing to fail underperforming students.

Issues of validity and reliability in the assessment of competence are critical to universities given that students are usually assessed by different clinicians (McGrath et al. 2006; Ossenberg & Henderson 2015; Vinales 2015b; Zasadny & Bull 2015). A complicating factor is the differences in instruments that exist nationally and internationally for the purpose of assessing the clinical competence of undergraduate nursing students. Despite the fact that the *National Competency Standards for the Registered Nurse* (NMBA 2006) forms the basis of all competency assessments, to date, a wide variety of assessment tools remain in use in nursing schools across Australia (Crookes et al. 2010; Ossenberg & Henderson 2015; Zasadny & Bull 2015). The challenges faced by clinicians who have to navigate the enormous variety of assessment approaches and tools used by different universities were raised by participants in this study.

According to Crookes et al. (2010), such lack of parity in assessment of competence could lead to varying outcomes for newly graduated RNs, within and between programmes in Australia. As such, several efforts have already contributed to the development of assessment tools for undergraduate nursing

students, which have the potential to be implemented nationally across Australian universities (Crookes et al. 2010; Ossenberrg & Henderson 2015; Zasadny & Bull 2015).

The above discussion illustrates how the lack of consistency in student supervision and assessment of clinical competence, as perceived by participants, impacts graduate RNs' preparation and practice readiness. These differences again reflect participant's different **system drivers**, which in turn, influence their perspectives and contributes to them **Inhabiting Disparate Realities**.

This concludes the discussion on the sub-category **curricula** as one of the **system drivers**, and how it sits in relation to the existing literature. Reference to **skill-mix** within the existing literature will now be discussed in further detail.

Skill-Mix

The term "skill-mix" is used to describe the mix of role/position, scope of practice, and level of experience of nurses rostered to work with patients on a single shift (Duffield et al. 2011; Jacob, McKenna & D'Amore 2015). Duffield et al. (2005, 2011), explain that increased patient acuity and shortened lengths of stay have significant impact on nurses' skill mix levels. These issues require more skilled nurses in order to ensure the provision of safe patient care (Duffield et al. 2005, 2011). This is corroborated by the findings of a recent European study which determined that clinical settings where nurses cared for fewer patients each and a higher proportion had bachelor's degrees had significantly lower mortality rates (Aiken et al. 2014).

NUMs are charged with the responsibility of ensuring the provision of safe and optimal patient care within an authorised budget. It is also an expectation that NUMs enable a positive learning environment for nursing students and graduates in their designated wards. In this study, the tension between the need for NUMs to maintain a safe skill-mix on one hand and to manage within the fiscal constraints on another while also supporting novice clinicians was verbalised by participants

In an Australian study undertaken in Queensland in 2001, over 30 percent of nurse participants expressed concerns regarding heavy workloads and poor skill-mix due to lack of funding, increased numbers of inexperienced nurses and decreased numbers in experienced nurses (Hegney, Plank & Parker 2003). In another Australian study aimed at linking nursing skill-mix, workloads and patient outcomes, Duffield et al. (2005) identified that due to increased patient acuity and shortened lengths of stay, more skilled nurses are required in order to ensure the provision of safe patient care.

Furthermore, several national and international studies and reviews have consistently contended that improved patient outcomes, reduced patient morbidity and shorter length of stay are linked to improved staffing ratios, particularly where higher proportions of RNs care for fewer patients (Aiken, Clarke & Sloan 2000; Aiken et al. 2001, 2003, 2014; Duffield et al. 2005, 2011; Jacob, McKenna & D'Amore 2015; Lang et al. 2004; Twigg et al. 2013).

Despite the will to improve staffing ratios and to support novice graduates, the challenges that NUMs contend with, when rostering graduate RNs was illustrated in this study. Even though the NUMs in this study recognise graduates to be

novices, their **system drivers** do not always allow them to offer their graduates a lighter patient allocation. This finding is congruent with the findings of several other studies.

In another Australian study, graduates reported that where staffing was short, some of them were required to take a patient load before they even received induction (Fox, Henderson & Malko-Nyhan 2005). In a paper titled *The nature of nursing and the education of the nurse*, Dorothy Hall (1980), the Regional Officer for Nursing, World Health Organization (Regional Office for Europe) cautioned against having unrealistic expectations of graduate RNs and suggested that nurses are the only health professionals who are expected to be a completely finished product when they finish their basic training. Hall's 'warning' over three decades ago, highlights the unrealistic expectations of graduates. Horsburgh (1989) noted that newly graduated RNs are expected to supervise enrolled nurses and students. Given these sentiments were voiced many years ago – it begs the questions, “Has anything changed and if not – why not”?

In this study, rostering strategies and challenges related to maintaining safe **skill-mix** levels while ensuring the safe provision of patient care were discussed by both NUMs and BNPCs reflecting a lack of consistent approach.

Calling for national consistency, the Australian Nursing Federation (ANF 2009, p. 9) recommended that ‘health care providers must ensure a safe skill-mix, which includes experienced nurses working each shift to ensure that graduate and beginner nurses are adequately mentored and supervised’. Winfield, Melo and

Myrick (2009, p. E12) called for new graduates to be offered more supernumerary time and proposed that...

Nurse managers and clinical educators must look beyond immediate fiscal restraints to viable long-term solutions that not only fill staffing quotas but also prepare future practitioners in a manner that embodies the caring that is the hallmark of the nursing profession.

As a result of **system drivers**, NUMs are required to ensure a safe **skill-mix**, while being restricted by current staffing approaches and fiscal constraints. Such **system drivers** in turn, influence participants' perspectives of graduate RNs and contribute to them **Inhabiting Disparate Realities**.

This concludes the discussion on the sub-category **skill-mix** and how it is informed by existing literature. A discussion of **fiscal constraints** and its relationship with the literature will now ensue.

Fiscal Constraints

Both participant cohorts talked about fiscal constraints. As the following discussion elucidates, both cohorts have the same challenges, yet from a different perspective. This is yet more evidence of how participants are **Inhabiting Disparate Realities**. In this study, BNPCs discussed the financial impact related to providing students with additional placement hours while NUMs discussed the financial cost associated with providing additional support and supernumerary time for newly graduated RNs.

In Australia, varying approaches to costing clinical placements for undergraduate health students are applied nationally with very little consistency across the

different States and Territories and also within health disciplines (Paxton Partners 2013). In 2002, Australian nurse leaders warned that nursing clinical placements were constrained by cuts in financial resourcing (Clare et al. 2002). The *National Review of Nursing Education 2002: Our Duty of Care Report* (Heath et al. 2002) recognised the significance of clinical exposure in nursing education but also acknowledged the related costs and burden to host services and also universities. As a result of this review, and cognisant of recommendation twenty-four of the report (Heath et al. 2002, p. 26), considerable additional funds (\$54 million over 5 years) were devoted by the Commonwealth Government in 2004, to BN programmes to enhance clinical placement capacity. The *National Nursing and Nursing Education Taskforce* (N3ET 2006) conducted a survey aimed at evaluating how universities utilised the additional clinical placement funds. Results indicated a level of dissatisfaction with the scheme and identified several factors that contributed to the spiralling costs of clinical placement. Among these factors are the minimum regulatory requirements for clinical placement, increased administrative costs for the increased number of students and clinical placement hours, and increased charges by health services for the provision of student placement (N3ET 2006).

Australian universities continued to express concerns that the escalating costs associated with clinical placements threatened the sustainability of nursing programmes (Buchanan, Jenkins & Scott 2014; Clare et al. 2002; Grealish & Carroll 1998; N3ET 2006). This sentiment was also shared by participants in this study.

In their submission to the *Productivity Commission Health Workforce Study* on 29 July 2005, the Council of Deans of Nursing and Midwifery in Australia and New Zealand (CDNM 2005, p. 2) highlighted the problems associated with government funding for undergraduate education of RNs by stating that:

Nursing is currently designated as a National Priority and funded at \$9,316 per EFTSL yet when this is compared to the funding received by universities for medical students, 14,738 per EFTSL, it hardly represents a significant amount for an area designated as a priority. The problem for schools of nursing is primarily related to accessing and funding quality clinical placements for undergraduate students within the current inadequate funding model.

In 2009, Health Workforce Australia (HWA) was formed under the *Health Workforce Australia Act 2009* to provide financial support in order to enable further growth in clinical placement capacity. Five years later, a scoping study commissioned by the University of Sydney, NSW regarding the costs and benefits of clinical education in Australia warned that clinical education in Australian universities has reached a critical stage (Buchanan, Jenkins & Scott 2014). This scoping study aimed to enhance the understanding of benefits as well as costs and burden of clinical placements of undergraduate health students to hosting facilities and also to universities (Buchanan, Jenkins & Scott 2014). Buchanan and colleagues (2014) acknowledge that while the benefits of clinical placements to health institutions such as the provision of direct and indirect clinical services are prevalent, they are difficult to measure and document.

The UK Department of Health acknowledged the service contribution of undergraduate nursing students on clinical placements, but it could not ‘quantify the costs or benefits of their presence to the host organizations’ (Jones & Akehurst 2000, p. 433). Jones and Akehurst (2000) argue that paying for clinical training

ought to be considered inappropriate because it assumes that education is an additional activity, rather than a fundamental part of the mission of teaching hospitals. However, they also acknowledge that introducing a system of payments might act as an incentive to service providers to provide clinical placements (Jones & Akehurst 2000).

Australian universities pay for clinical placements yet there remains a shortfall of clinical places and funding. Clinical placement arrangements are different in the case of non-nursing professions such as occupational therapy and physiotherapy, also referred to as Allied Health. In the State of Queensland, Australia, a clinical placement guide authored by the state government (Queensland Health 2014) considers the clinical placement of undergraduate students of allied health to be a core responsibility of all its allied health employees. While acknowledging the recent unprecedented growth in student numbers, Queensland Health (2014) continues to expect that payment for allied health placements occurs only to accommodate the requests for additional student placements after reaching placement capacity. Unfortunately, this does not appear to be the case in relation to the clinical placements of undergraduate nursing students where universities continue to be charged by health services for the provision of clinical placements (Buchanan, Jenkins & Scott 2014; Paxton Partners 2013).

The above discussion highlights the **fiscal constraints** experienced by education providers in relation to clinical placement cost. Such **fiscal constraints** act as one of the **system drivers** that contribute to the variation in BN curricula as discussed in the previous section. Another reference to **fiscal constraints** in this study was with regard to the challenges faced by NUMs when having to balance a stringent

ward budget while also having to offer graduate RNs additional support and supernumerary time.

The views of participants in this study are congruent with the findings of national and international studies. In an Australian study exploring the transition experience of graduate RNs, De Bellis et al. (2001) argued that economic constraints and rationalisation in healthcare settings have contributed to the lack of adequate support for graduates in their initial period of employment. In a more recent North American study describing a successful transition programme, Dyess and Parker (2012) concede that providing new graduates with additional resources such as supernumerary time and monetary support is usually very challenging for health services. Similarly, a Taiwanese study (Feng & Tsai 2012, p. 2068) that explored the socialisation experiences of new graduate nurses found that the speed and effectiveness of the adjustment of new graduates have significant economic implications for hospitals. As such, nurse managers were compelled to hasten the adjustment of new graduates, which was experienced as harsh and not well supported (Feng & Tsai 2012).

System drivers in this study relate to monetary and regulatory processes and to standards that govern both the practice and education sectors at macro level i.e. curricula composition/requirements and accreditation standards (ANMAC 2012; NMBA 2006) and at micro level i.e. skill-mix at unit/ward level and budget requirements.

This concludes the discussion on the category **system drivers** and how it is positioned within scholarly discourse. The second category, **enculturation**, will now be discussed.

Enculturation

Enculturation is one of the categories that emerged from the data encompassing two different aspects. These being, professional and contextual enculturation. It was apparent that both the BNPC and NUM participants agreed on the significance of **contextual enculturation** and **professional enculturation** for graduate RNs attaining practice readiness. However, opinions differed on the focus and timing of when graduates should attain **contextual** and **professional enculturation**. Some participants suggested **contextual enculturation** should already be developed upon commencement of employment to enhance the transition experience of newly graduated RNs. Others asserted that it should occur post-employment. In reference to **professional enculturation**, NUM participants expect desired graduate attributes to be fully developed at time of employment. In contrast, BNPCs think these attributes should be allowed to mature over time. Such variation in focus emanates from the fact that NUMs and BNPCs view newly graduated RN practice readiness through different lenses influenced by varying **system drivers**. Once again, illustrating how participants are **Inhabiting Disparate Realities**.

Each of these sub-categories will now be discussed and existing literature will again be drawn upon. The discussion commences with the sub-category **professional enculturation**.

Professional Enculturation

Professional enculturation is about constructing a sense of professional identity (De Bellis et al. 2001; Willetts & Clarke 2014) and attaining the desired graduate attributes that participants considered to be significant contributors to newly graduated RN practice readiness. Participants deemed such attributes essential for newly graduated RNs so as to be able to assimilate with the professional identity of the generalist RN who is required to meet the *National Competency Standards for the Registered Nurse* (NMBA 2006). In this study, desirable graduate attributes that reflect **professional enculturation**, were identified by participants to include a nurse who is a '*critical thinker*'; '*reflective practitioner*'; '*life-long learner*'; '*good communicator*'; '*team player*'; and someone who is '*safe*', '*caring*' and '*able to perform basic clinical skills*'.

The skills and attributes, representing **professional enculturation**, are consistent with the existing literature despite the lack of consensus regarding what constitutes graduate attributes. Such lack of consensus again highlights the nebulous nature of practice readiness.

Historically, academic achievements like clinical knowledge and skills attainment were considered as the main criteria of graduate competence for employment. However, there has been growing recognition and demand by employers that

graduates should possess a wide range of other skills and attributes that sit outside of the clinical domain (AC Nielsen 2000; Caballero, Walker & Fuller-Tsyzkiewicz 2011; Carless 2007; Walker et al. 2013).

The Australian Council for Educational Research (ACER 2001) developed a measure of generic skills and attributes that could be administered by universities at entry and exit level. Wide key stakeholder consultation with employers and university representatives resulted in the development of the *Graduate Skills Assessment (GSA)*. The GSA encompassed four components; critical thinking, problem solving, interpersonal understandings, and written communication (ACER 2001). Furthermore, the *Graduate Skills Assessment Summary Report* (ACER 2001, p. 28) explains that,

Although written communication, problem solving, critical thinking and interpersonal understandings were chosen, these involve skills such as analysis, logical reasoning, literacy, numeracy, empathy and, to some extent, creativity, which are listed separately. In addition, an ability to identify and absorb key information, reflect and organise one's thoughts and actions would seem to be important for success in all the four chosen components, and would be related to a capacity for lifelong learning.

Nursing is not the only discipline that requires particular graduate attributes. Casner-Lotto and Barrington (2006) conducted a large North American study where they surveyed human resource professionals regarding the necessary skills for success in the workplace of the 21st century. Outcomes of the study identified oral and written communication, professionalism and work ethics, and critical thinking and problem solving, to be essential skills for students' success and for their ability to compete in the workplace (Casner-Lotto & Barrington 2006). Similarly, a national survey of graduate recruitment coordinators from a wide

range of industry sectors was undertaken to identify current recruitment and selection practices in Australia (Carless 2007). Carless (2007, p. 154) noted that ‘graduates are sought that are not only smart and able to learn quickly, but also are adaptable, responsible, and able to work with others’.

Nursing has also attempted to identify specific graduate attributes. Another North American study, which utilised qualitative and quantitative approaches, invited 200 preceptors to identify their views of new graduates’ readiness for practice (Hickey 2009). Hickey (2009, p. 38) analysed the research data to then determine the following attributes to be most important for newly graduated RNs to transition to practice. The results are presented in Table 6 below.

Table 6: Graduate attributes for the newly graduated RN (Hickey 2009, p. 38)

Graduate attributes for the newly graduated RN	
1 Psychomotor skills	patient safety; IV medications; medication administration: five rights; drug interactions; dressing changes, Foley catheter care and insertion; management of tubes and drains; pumps; safety
2 Assessment skills	head-to-toe, re-evaluating patient responses
3 Critical thinking	problem solving, prioritization, decision making, self-confidence, motivation
4 Time management	organization, caseload management, delegation
5 Communication	written and verbal, documentation
6 Teamwork	working with ancillary staff, working with other RNs

The study also highlighted several areas of deficit in newly graduated nurses, suggesting that the clinical experiences offered during undergraduate programmes did not adequately prepare them for practice (Hickey 2009). As a result, Hickey

(2009, p. 39) recommended that ‘students should experience more of the reality of nursing during their academic preparation’.

Given the lack of consensus regarding graduate attributes for nurses and the diversity of skills and qualities required (Caballero, Walker & Fuller-Tsyzkiewicz 2011; Walker & Campbell 2013; Walker et al. 2013), once again practice readiness emerges as a nebulous construct. Such diversity is reflected in the health graduates’ *Work Readiness Scale (WRS)*. The WRS was developed in Australia and includes four distinct dimensions. These are: organisational acumen, social intelligence, personal characteristics and work competence (Caballero, Walker & Fuller-Tsyzkiewicz 2011). Furthermore, similar results suggestive of the challenge to articulate what it means to be practice ready, were reported in a recent qualitative study conducted in Victoria, Australia (Walker et al. 2013). Walker and colleagues (2013) aimed to explore work readiness factors that impacted medical and nursing graduates’ transition and integration into practice. Given that the delivery of healthcare in the Australian public healthcare system utilises a multidisciplinary team approach, Walker et al. (2013, p. 116) note that health graduates ‘who possess teamwork and communication skills may experience a smoother transition into the workplace compared with graduates lacking such skills’.

In a critical review of the literature exploring factors and theoretical perspectives that contribute to the practice readiness of newly graduated RNs in the UK, Monaghan (2015, p. e5) found that the theory-practice gap ‘appears to be most pronounced within clinical skills capabilities’. Similarly in this PhD study, participants’ perception of a lack of basic, fundamental clinical skills emerged.

The need to possess basic, fundamental clinical skills as a desired attribute for graduate RN practice readiness as described by the participants in this current study is indicative of the need to **hit the floor running**. This finding resonates with the findings of two other Australian studies (Caballero, Walker & Fuller-Tsyzkiewicz 2011; Walker et al. 2013). According to Walker et al. (2013, p. 121),

... employers expect graduates to possess these work competencies before entering the workplace. ... A lack of clinical experience undermined graduates' confidence in their skills and knowledge, leading to a stressful workplace transition.

This posits the argument that a philosophical tension exists between liberalism and vocationalism within a practice based profession such as nursing (McAllister 2001). McAllister (2001, p. 306) explains that 'the modern concept of liberal education involves the study of a broad range of subjects, rather than specialization ... [and] focuses on mastery of content rather than technique'. This tension was evident in this study where NUMs focused on the ability of graduates to perform clinical skills and BNPCs focused on graduates being critical thinkers and reflective practitioners.

McAllister (2001, p. 306) adds that such tension has contributed to students being 'caught in a struggle to become either competent practitioners or knowledgeable life-long learners'. McAllister (2001, p. 307) further suggests that nursing education should focus on 'balancing the development of vocational, or doing skills, and metacognitive, or learning skills'.

In a multifaceted practice-based profession such as nursing, nurse educators are consistently challenged to better integrate theoretical content with the reality of

clinical practice (Crookes, Crookes & Walsh 2013; Flood & Robinia 2014). Like all adult learners, nursing students more fully engage with theoretical learning when they realise its application and relevance to their clinical practice (Knowles 1984). Clinical practice is often the vehicle by which students make sense of their theoretical knowledge. As such, classroom-practice discord resulting from nursing students' theoretical and clinical experiences being perceived as disconnected, might lead to their dissatisfaction with the profession (Flood & Robinia 2014). When exploring strategies and teaching approaches adopted by nurse educators to address the challenges of classroom-practice discord, Crookes and colleagues (2013, p. 239) found that:

Nurse educators share the view that undergraduate students are often only really willing to engage with topics if they can see the implications of and/or the application to their practice and this is only achieved if nurse educators deliver content in a meaningful and engaging way that links theory to practice.

The philosophical tension between liberalism and vocationalism in nursing education as discussed by McAllister (2001) contributes to NUMs and BNPCs to be **Inhabiting Disparate Realities**, which shapes their perspectives.

In this PhD study, participants also highlighted that being a caring person is a desired graduate attribute. This is topical given the recent concerns aired in the UK regarding the perceived erosion of care and compassion in the nursing profession following the publication of the *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry* (Francis 2013). This report offers an account of the serious failings of an acute public health service within the UK National Health Service (NHS) at delivering acceptable standards of care to its patients.

Considerable public outcry regarding the perceived erosion of care and compassion among clinicians including nurses at Mid Staffordshire followed the release of the report. Given the gravity of such failings, one of the recommendations of the *Francis Report* (Francis 2013, P. 76) is that:

There should be an increased focus on a culture of compassion and caring in nurse recruitment, training and education. Nursing training should ensure that a consistent standard is achieved by all trainees throughout the country. The achievement of this will require the establishment of national standards. The knowledge and skills framework should be reviewed with a view to giving explicit recognition to nurses' commitment to patient care and the priority that should be accorded to dignity and respect in the acquisition of leadership skills.

Paley (2013, p. 1452) criticised the *Francis Report* and argued that it was not a deficit of care and compassion that led to the appalling care at Mid Staffordshire, 'but a series of contextual factors that are known to affect social cognition'. Such contextual factors included under-staffing and having to care for patients who have high levels of dependency (Francis 2013; Paley 2013). Timmins and de Vries (2014, p. 1271) agreed with Paley (2013) that blaming nurses for what happened at Mid Staffordshire is not the answer but at the same time acknowledged that:

nursing students and nurses are not passers-by and need to take their responsibility seriously. ... nursing students need to be prepared for this with a good grounding in ethics, empathy and compassion.

The views of Timmins and de Vries (2014) are congruent with those of participants in this PhD study, who identified being a caring person as a desired graduate attribute.

Being a reflective practitioner was another desired attribute discussed by participants in this study that was considered necessary for newly graduated RN practice readiness. Schon (1983) identified two aspects of reflection; reflection-in-action and reflection-on-action. He explained that reflection-in-action is ‘reflection on phenomena and on one’s spontaneous ways of thinking and acting, undertaken in the midst of action to guide further action’, while reflection-on-action is reflection after the event (Schon 1988, p. 22). He argues though, that thinking and reflecting is different when in the real clinical environment to that which occurs in a structured learning environment (Schon 1987). According to James and Clarke (1994, p.84), ‘reflection is an integral part of experiential learning and the development of practical knowledge’. This corroborates the views of participants in this PhD study that being a reflective practitioner is a desired attribute to graduate practice readiness.

Drawing on literature, this section depicted a lack of consensus regarding what constitutes graduate attributes. The discourse above is an additional demonstration of the nebulous nature of practice readiness. Both cohorts of participants in this study, identified desired attributes that would have a positive impact on graduate RN practice readiness. However, opinions differed as to when graduates should attain such attributes, upon or after commencement of employment. Such variation in focus emanates from the fact that NUMs and BNPCs view newly graduated RNs practice readiness through different lenses, demonstrating yet again that they are **Inhabiting Disparate Realities**. The next sub-category to be discussed is **contextual enculturation**.

Contextual Enculturation

The other aspect of enculturation that emerged in this study is **contextual enculturation**. The notion of **contextual enculturation**, as posited by participants, is about newly graduated RNs being familiar with the intricacies of organisational knowledge and being able to develop a sense of belonging, i.e. coming to terms with the local context, practice guidelines and clinical standards where graduates are usually employed.

Contextual enculturation was described by participants in this study as a significant contributor to newly graduated RN practice readiness. Participants discussed having clinical schools in hospitals where students who are familiar with the wards and the staff become direct feeders for graduate programmes. This enables graduates to overcome some of the idiosyncrasies involved with individual health services. As such, participants suggested that **contextual enculturation** would enable new graduates to focus on consolidating their clinical knowledge and skills and would enhance their transition into professional practice.

The link between **contextual enculturation** and graduate practice readiness is highlighted in the findings of two other Australian studies (Caballero, Walker & Fuller-Tyszkiewicz 2011; Walker et al. 2013), which identified organisational acumen as being an essential work readiness attribute. The *Work Readiness Scale* (Caballero, Walker & Fuller-Tyszkiewicz 2011) found that organisational acumen was one of ten attributes that comprise work readiness. As part of developing the *Work Readiness Scale*, Caballero and colleagues defined organisational acumen as

the ‘understanding of organisational structures’ and the ‘awareness of organisational culture’ (2011, p. 45).

In an earlier Australian study, which explored the factors that assist or hinder graduate RNs’ knowledge and skill acquisition, Newton and McKenna (2007, p. 1236) found that learning the ‘ward culture’ was critical to graduates’ assimilation into the clinical environment. They add that being familiar with the ‘the rules’ and ‘prevalent hierarchy’ of the ward, enable graduates to take time to learn and focus on developing their knowledge and skills (Newton & McKenna 2007).

Draper et al. (2014) suggest that being familiar with the practice setting means that students who become graduates are already known to their mentors and require limited orientation to the clinical setting. Familiarity with the practice setting has been reported to ease newly graduated RNs’ transition to practice (Draper et al. 2014; Kenny et al. 2012) and enhance team work and decision-making skills (Phillips et al. 2012a).

Based on their findings, Levett-Jones and colleagues (2008) called for a reconsideration of educational principles, practices and assumptions that underpin clinical placement models and duration. This is significant, given that current educational principles, practices and assumptions call for students to be exposed to a variety of clinical settings for the purpose of gaining a wide range of clinical exposure (ANMAC 2012; Walker 2005).

Walker (2005) opposed students being rotated repeatedly and highlighted the value of keeping the students in the same clinical environment for the whole semester. She argued that such a placement model enables students to ‘develop a

deep familiarity with the context in which they are working, which then enables them to relax ... and thereby concentrate on the development of skills and knowledge' (Walker 2005, p. 38).

Clinical placement models and duration contribute to **contextual enculturation**. Where some participants in this study called for extending clinical placement time in the acute setting to enable graduates to develop **contextual enculturation** in such clinical context, others preferred students being rotated repeatedly to a variety of clinical settings to ensure broad clinical exposure.

The significance of **contextual enculturation** was highlighted in a study from the UK (Gerrish 2000, p. 474), which found that graduate RNs felt inadequately prepared for their role and recommended that more attention should be placed on the ...

development of clinical, organizational and management skills in pre-registration courses and the bridging period between the latter part of the course and the first 6 months post-qualification, in order to enable the neophyte nurse to acclimatize gradually to becoming an accountable practitioner.

Houghton (2014) undertook a critical review of organisational socialisation literature to better understand how nursing students adapt to clinical practice and to consider strategies that can be used to enhance students' learning experiences. This review revealed that socialisation is a significant factor that enhances student learning (Houghton 2014). This review also revealed that students usually find it easier to adapt if they have some prior knowledge of the clinical context (Houghton 2014). Houghton (2014) added that students learn more effectively and develop positive relationships with colleagues and staff when they feel a sense of

belonging. Furthermore, developing a sense of belonging has been identified as one of the key elements to the construction of students' nursing identity (Walker et al. 2014).

Interestingly, hospital trained nurses were perceived to be contextually enculturated and that was the purpose of such apprenticeship style training. Prior to the transfer of nurse education in Australia to the tertiary sector, student nurses were recruited directly by hospitals where they resided in nurse's quarters and at the same time undertook their training (Fetherstonhaugh, Nay & Heather 2008; Mannix, Wilkes & Luck 2009). Mannix, Wilkes and Luck (2009, p. 60) suggest that these student nurses 'grew to know the ways and the idiosyncrasies of their training hospitals ... and were accepted as being an integral part of hospital life and central to the nursing workforce'. Contextual knowledge was found in a Canadian study to be a key distinguishing characteristic of graduates of hospital programmes where students became familiar with the employing hospital and gained social wisdom as well as knowledge of local policies and procedures (Wolff, Pesut & Regan 2010).

An Australian study involving forty-one graduate health professionals and five organisational representatives identified organisational acumen as one of four categories contributing to work readiness (Walker et al. 2013). Walker et al. (2013) explained that organisational acumen implied having knowledge of the ward and of hospital policy and procedures. In Australia, two studies found that the recruitment of graduate RNs who are organisationally savvy was considered a potential advantage for industry (Nash, Lemcke & Sacre 2009; Watt & Pascoe

2013). Graduates who had these characteristics were perceived to be more practice ready.

Another study, this time in North America found that students who were familiar with the hospital environment transitioned better as graduates (Hickey 2009). This is consistent with the findings of the Canadian study by Wolff, Pesut and Regan (2010), which highlighted the significance of contextual knowledge for new graduates to practice safely. Participants of that study believed that the prolonged exposure to one clinical setting contributes to new graduates' sense of belonging, which enhances their confidence in their abilities to provide clinical care (Wolff, Pesut & Regan 2010).

The importance of attaining a sense of belonging was central to the work of Abraham Maslow (1943), a humanist psychologist, who first introduced the concept of hierarchy of needs and what motivates people to satisfy these needs. In his seminal work *Theory of Human Motivation*, Maslow (1943) hypothesised that people's actions are motivated by a hierarchy of five sets of needs, and unless each set is met, a person is unable to move to the higher set of needs in the hierarchy. Maslow's hierarchy of needs includes the human need to belong to a community and to be accepted and valued by other people in their community (Maslow 1943).

Despite remaining popular and widely applied across many disciplines, Maslow's (1943) *Theory of Human Motivation* has been challenged by other psychologists over the years (Neher 1991; Rutledge 2011; Smith 1973). Both Neher (1991) and Rutledge (2011) disputed the hierarchical nature of Maslow's needs. However,

Rutledge (2011, p. 1), as illustrated in Figure 25, argued that none of Maslow's needs could be met without social connection and that:

Needs are, like most other things in nature, an interactive, dynamic system, but they are anchored in our ability to make social connections. ... Belongingness is the driving force of human behavior, not a third tier activity. ... Belonging to a community provides the sense of security and agency that makes our brains happy and helps keep us safe.



Figure 25: Maslow Rewired

<http://mprcenter.org/blog/wp-content/uploads/2011/11/Maslow-Rewired.jpg>

Regardless if we were to adopt Maslow's (1943) *Theory of Human Motivation* or Rutledge's (2011) more recent adaptation of the theory, it is evident that learners need to attain a sense of belonging through **contextual enculturation** to reach their potential and achieve self-actualisation. In other words, for students and graduates to accomplish optimal learning and performance in a clinical setting, they need to firstly, attain a sense of belonging and to be accepted and valued by

the team they work with (Malouf & West 2011). Social exclusion and lack of belongingness are known to negatively impact on peoples' intelligent performance and cognitive processes (Baumeister, Twenge & Nuss 2002; Levett-Jones & Lathlean 2008; Malouf & West 2011). Therefore, it is essential for nursing students to have the opportunity to develop a sense of belonging while undertaking clinical placements.

The significance of belonging was the focus of a mixed-method, multi-site study exploring the experience of third year nursing students while on clinical placement (Levett-Jones et al. 2007). Levett-Jones and colleagues (2007, p. 172) used a montage of students' stories from two universities in Australia and one from the UK, to illustrate that:

A sense of belonging to the nursing team is crucial to a positive and productive learning experience. Anyone having experienced the ordeal of feeling unwelcome and unaccepted in the workplace will understand the importance of workplace collegiality and belongingness.

The desire to 'fit in' or to 'belong' was one of the findings of an Australian study that explored the experiences of nine newly graduated RNs as they transitioned to acute care nursing practice (Malouf & West 2011). Graduates in that study reported that knowing people and establishing social ties within the workplace is essential to their professional growth and development as RNs (Malouf & West 2011). These findings were consistent with another Australian study, which explored the impact of a university-based clinical school of nursing on the perception of graduate RNs regarding their practice readiness (Watt & Pascoe 2013). The study found that being familiar with the physical environment;

organisational culture and clinical resources enabled new graduates to become part of the team and to focus on their professional development (Watt & Pascoe 2013).

The significance of belonging or ‘being an insider’ was also one of the findings of a study undertaken in Taiwan to explore the socialisation experiences of new graduate nurses (Feng & Tsai 2012, p. 2067). Graduates found it most challenging to fit into the ‘bureaucratic system, such as maintaining interpersonal relationships with colleagues and familiarising themselves with the ward rules and culture’ in addition to having to learn new knowledge and skills (Feng & Tsai 2012, p. 2068). Feng and Tsai (2012) established that being familiar with the bureaucratic system, their colleagues, ward rules and culture would enable graduates to focus on learning new knowledge and skills.

It is apparent that attaining **contextual enculturation** lessens the impact of ‘*reality shock*’ or ‘*transition shock*’. This is significant with far-reaching implications for nursing education and practice given the considerable stress experienced by newly graduated RNs in the initial stages of employment.

The findings of this PhD study depict the difference in focus among participants in relation to **contextual enculturation**. NUM participants in this study expressed their dissatisfaction in what they perceived as insufficient clinical exposure in the acute care setting to enable **contextual enculturation**.

While many participants in this study called for changes in clinical placement models and duration to enable **contextual enculturation** at commencement of employment, others promoted broad clinical exposure and contended that

graduates should be supported post-employment to attain **contextual enculturation**. A further demonstration of how **Inhabiting Disparate Realities** results in a variation in perspective and focus.

This concludes the discussion on the sub-category **contextual enculturation** and how it sits in relation to the existing literature. The category **hit the floor running** will now be discussed.

Hit the floor running

NUMs and BNPCs have varying **system drivers**, which contribute to them **Inhabiting Disparate Realities**. As a result, their priorities and expectations regarding graduate RN practice readiness were inevitably going to be different. Participants discussed and reflected on what they perceived was expected of (and by) newly graduated RNs. Although all participants acknowledged that newly graduated RNs are novices and that **professional** and **contextual enculturation** contribute to their practice readiness, their reflections revealed differences in their expectations of graduates. As a consequence, newly graduated RNs are expected to **hit the floor running** as they commenced employment.

The debate regarding the notion of unrealistic expectations of newly graduate RNs is not new and is certainly not limited to Australia. Indeed, as discussed earlier, this debate was the genesis for this PhD study. The expectation of health employers that newly graduated RNs should **hit the floor running** and perform their role and duties just as any other experienced RN, has long been, and continues to be, recognised as unrealistic (De Bellis et al. 2001; El Haddad 2014;

Evans, Boxer & Sanber 2008; Greenwood 2000; Hall 1980; Horsburgh 1989; Lauder et al. 2008; Madjar et al. 1997; Romyn et al. 2009; Thoms 2014; Wangensteen, Johansson & Nordstrom 2008; Wolff, Pesut & Regan 2010). The expectation 'to produce RNs who can hit the ground running with respect to service provision' (Greenwood 2000, p. 17) is a consistent theme in the literature.

In the study presented in this thesis, NUMs said they need newly graduated RNs to **hit the floor running** especially in a climate of limited funding for graduate support. To be expected to **hit the floor running** can cause stress. In an Australian study, stress was expressed by graduate participants who perceived that they were expected to 'function as a registered nurse with a full patient load in a very short period of time' without the support they needed (De Bellis et al. 2001, p. 91). A different Australian study identified apparent dissatisfaction with the level of preparation of nursing students and their ability to function as RNs upon graduation (Evans, Boxer & Sanber 2008).

A more recent study conducted in Norway revealed that newly graduated RNs experience uncertainty and unfamiliarity with routines, highlighting the need for a supportive environment and recommending that newly graduated nurses are offered induction programmes and spared from being the only nurse on a shift (Wangensteen, Johansson & Nordstrom 2008). Nursing students and newly graduated nurses require a nurturing environment and practical support to facilitate their entry to the profession (Henderson & Tyler 2011; Lamont, Brunero & Woods 2015).

In the UK, several studies reported that healthcare employers appear to have low expectations of competence of newly graduated RNs' who also reported feeling underprepared for the challenges of transition (Andrews et al. 2005; Clark & Holmes 2007; Roxburgh et al. 2010).

While NUMs and BNPCs continue **Inhabiting Disparate Realities** as a result of varying **system drivers**, their priorities and expectations regarding graduate RN practice readiness will inevitably be different. This in turn will continue to lead to unrealistic expectations of newly graduated RNs and the perception that new graduates are not practice ready when these expectations are not met.

Chapter Summary

This chapter considered the study's findings and discussed how these findings are positioned within scholarly discourse. This discussion highlighted alignment with existing research but also demonstrated the unique and significant contribution this study made to the body of nursing knowledge. Drawing upon existing literature, this chapter presented a comprehensive discussion of the identified substantive theory, *Practice Readiness: A Nebulous Construct*, the core category, **Inhabiting Disparate Realities** and each of the three categories with their associated sub-categories.

The discussion in this chapter incorporated the established knowledge in relation to the lack of clarity around the expectations of what newly graduated RNs 'should' be able to do and the level of responsibility they 'should' be able to take on, upon entry to practice. Such lack of clarity was also demonstrated by

participants within this study, illustrating the nebulous nature of practice readiness.

The discussion also incorporated the established knowledge in relation to varying **system drivers** that emerged within this study, such as **curricula**, **skill-mix** and **fiscal constraints**. Such varying **system drivers** impacted the decisions, priorities and expectations of NUMs and BNPCs and as such informed their perspectives regarding graduate RN practice readiness. As a result, participants were **Inhabiting Disparate Realities**, which fundamentally meant that NUMs and BNPCs, as a result of varying **system drivers**, view graduate RN practice readiness through different lenses.

The extensive discussion also incorporated knowledge in relation to **professional** and **contextual enculturation** and how both were perceived to contribute to graduate practice readiness. However, participants' opinions in this study differed as to the focus and timing of when graduate RNs should attain **professional** and **contextual enculturation**. Whilst acknowledging newly graduated RNs are novices, they were also expected to **hit the floor running** as they commenced employment.

Inhabiting Disparate Realities can therefore be seen as a multifarious interplay of numerous features that in turn contribute to varied understandings of what it means to be practice ready. Hence, illustrating the emergence of the substantive theory namely, *Practice Readiness: A Nebulous Construct*.

Given that this research aimed to explore the perspectives of NUMs and BNPCs regarding newly graduated RNs' practice readiness, participants' voices were

purposefully privileged. Despite this research not setting out to explore solutions, strategies that were offered by participants believed to enhance graduate RN practice readiness, were discussed in light of existing literature. These strategies, other recommendations from this study and concluding statements will now be outlined in *Chapter Six*.

CHAPTER SIX

LIMITATIONS, RECOMMENDATIONS AND CONCLUDING REMARKS

Introduction

The preceding five chapters in this thesis have presented an introductory overview of the study, background and significance, research design, findings and discussion on how such findings were positioned within the literature. This final chapter concludes the thesis by highlighting the theoretical contribution to nursing knowledge, outlining the limitations of the study, and offering recommendations arising from this research as well as suggestions for future research.

Theoretical Contribution to Nursing Knowledge

As discussed in earlier chapters, an analysis of the literature revealed a spirited, longstanding debate in Australia and globally, as to whether newly graduated RNs are in fact practice ready. This longstanding debate highlights the apparent difference in opinion between the education and practice sectors on this issue. The need to explain the reasons for such enduring tension and longstanding debate, despite the considerable reform in nursing education and graduate transition programmes over the last three decades, provided impetus for the study. Hence, the purpose of this research was to understand what was happening that instigated such enduring tension and longstanding debate regarding graduate practice readiness in the Australian context. To achieve this, a Grounded Theory study was

conducted to explore the perspectives of BNPCs as representatives of the education sector and that of NUMs from the acute hospital setting as representatives of the practice sector. This led to the researcher interviewing a total of sixteen NUMs and BNPCs from across Australia to obtain their opinions and views on the issue of graduate RN practice readiness. As such, the study aimed to generate a substantive theory that explains the perspectives of NUMs and BNPCs regarding newly graduated RN practice readiness. This resulted in the conceptual emergence of the substantive theory ***Practice Readiness: A Nebulous Construct.***

The significance of this substantive theory is that it demonstrates the lack of clarity around the expectations of what newly graduated RNs ‘should’ be able to do and the level of responsibility they should be able to take on, upon entry to practice. The findings offer an explanation of how practice readiness, as it relates to newly graduated RNs in the Australian context, is viewed through different lenses in the practice and education sectors. As a result of varying **system drivers**, such as **curricula**, **skill-mix** and **fiscal constraints**, NUMs and BNPCs appear to be **Inhabiting Disparate Realities**. The findings further explain how such **system drivers** impact the decisions, priorities and expectations of NUMs and BNPCs and inform their perspectives regarding graduate RN practice readiness. The findings also elucidate how varying perspectives on when graduate RNs should attain **professional** and **contextual enculturation** contribute to graduates being expected to **hit the floor running** as they commence employment. The findings in this thesis expose how the perceived lack of meaningful collaboration and authentic partnership between the education and

practice sectors underpin the divergent worldviews and realities of the representative cohorts of both sectors. This explains how participants' epistemological dissonance due to contextual influences that are pragmatic and are shaped by their **Inhabiting Disparate Realities**, serve to perpetuate the longstanding debate that newly graduated RNs are not practice ready.

Despite the efforts made to ensure credibility in this research and despite the identified theoretical contribution to nursing knowledge, limitations exist in this study.

Study Limitations

All research has limitations (Creswell 1998; Schneider et al. 2013). Several limitations of this study are recognised. These limitations include the small number of interviewed participants (n=16), even though such sample number is consistent with the qualitative research approach. Like other qualitative research, the number of participants in this study was determined by the theoretical saturation of the data collected. The lack of demographic information from participants also constitutes a limitation of the study and impacts the transferability of the findings. Another limitation is the use of purposive and theoretical sampling methods. While the use of such sampling methods is a main feature of Grounded Theory research, participants who chose to take part in this study may have a different perspective on the topic of interest to those who chose not to participate. Furthermore, 'participants' statements may have been influenced by social desirability responses, perhaps limiting their candidness'

(Ashcroft & Lutfiyya 2013, p. 1320). Despite offering a robust rationalisation in *Chapter Four*, seeking the perspective of NUMs in acute hospital setting as representative of the practice sector, rather than NUMs of other clinical settings such as critical care, rural, community, mental health and others could be considered another limitation of the study. Even though every opportunity was made by the researcher to adhere to the main features of Grounded Theory methodology in order to safeguard the credibility of this research, such recognised limitations prohibit the ability to generalise the findings of this study. Nevertheless, the aim of qualitative research 'is not to produce evidence that allows for generalisation ... but rather it seeks to 'open up' debate and discussion in order to inform thinking' (Freshwater et al. 2010, p. 502). Consequently, the researcher hopes that the findings offered in this thesis, and subsequent publications, will contribute to a national debate and discussion regarding nursing education, the nature of partnerships between education and practice sectors, and the nature of what is expected of novice graduate RNs within the practice sector.

Despite its recognised limitations, this study has implications for peak nursing professional and industrial bodies and policy makers as well as the education and practice sectors in Australia. Based on the professional opinion of both cohorts of participants and as a result of the findings that emerged from this study, the following recommendations have been posited.

Recommendations for Consideration

This study has highlighted several key areas that should be addressed by multiple stakeholders at varying jurisdictions across Australia. As such, the recommendations offered for consideration are broadly categorised under the following headings:

1. Peak nursing professional and industrial bodies
2. Education sector
3. Practice sector

Peak nursing professional and industrial bodies

- The *National Competency Standards for the Registered Nurse* (NMBA 2006) should ensure that such standards take into consideration the novice status of newly graduated RNs. The expectation that newly graduated RNs should be able to provide ‘care in a range of settings that may include acute, community, residential and extended care settings, homes, educational institutions or other work settings’ on entry to practice (NMBA 2006, p. 2), just like other seasoned RNs, is not reasonable or realistic. Unfortunately the recent review of these standards has not taken into consideration the novice status of newly graduated RNs. The *Registered Nurse Standards for Practice* (NMBA 2016) do not appear to critically address this issue.
- Define the graduate RN identity to ensure that clinicians, employers and educators’ expectations of graduate RNs remain reasonable and realistic.

- Insist that adequate and consistent government funding is granted at a national level for increased clinical hours and optimisation of clinical placements.
- Insist that adequate and consistent government funding is granted at a national level to ensure all graduate RNs are initially supported in the induction period.
- Review BN curricula with the aim of achieving a theory-practice balance. As stated in earlier chapters, there has always been a spirited discourse regarding theory-practice gap, whether it was related to having more practice than theory or more theory than practice. The principles around theory-practice gap remain the same. One of the ways to move forward is to achieve a theory-practice balance. This can only be achieved through collaborative meaningful discussion between education and practice sectors as well as policy makers to agree on what that balance should look like.
- Review the *Registered nurse accreditation standards* (ANMAC 2012) to reflect clear strategies that can facilitate the development of meaningful collaboration and authentic partnerships between the education and practice sectors rather than what is currently perceived as non-authentic symbolic liaisons.
- Advocate for and support the implementation of a user friendly national competency assessment framework to minimise variability and ensure consistency in the assessment of clinical competence of undergraduate nursing students.

- Advocate for and support the implementation of a national transition support framework to enhance the support for newly graduated RNs. This framework needs to work towards diminishing the delineation of educational responsibilities, in which the education sector is mainly responsible for the pre-registration component and the practice sector is responsible for the post-registration component, which includes the transition of graduate RNs into the nursing workforce.

Education Sector

- Develop meaningful collaboration and authentic partnerships with the practice sector, based on a shared sense of accountability that diminish the delineation of educational responsibilities between the education and practice sectors and acknowledge the notion that preparing graduate RNs is a shared and equal responsibility between both sectors.
- Review the BN curricula with a focus on the links and the intersection between curricula and clinical interphase to enhance graduate RNs' transition experience.
- Enhance/optimize simulation programmes offered to undergraduate nursing students to further develop their fundamental clinical skills as an adjunct to clinical placement.
- Collaborate with the practice sector to align final year placements with graduate RN programmes to enable the attainment of **contextual enculturation** and to enhance the transition experience of graduate RNs.

- Privilege the depth rather than the breadth of clinical knowledge in nursing education. Acknowledge that no curriculum design will ever prepare an RN who can confidently and aptly work in all clinical settings such as aged care, acute care, critical care, community, and mental health, even at a novice level. So given that the majority of graduate RNs continue to be employed initially in acute hospital settings, students need to have good grounding and to develop **contextual enculturation** in such settings.
- Reconsider the focus on offering comprehensive or “generalist” nursing education by offering students brief clinical exposure to varying clinical settings so they can broaden their knowledge and skills. As the findings offered in this thesis suggest, preparing a generalist RN who can aptly work in any practice setting in any jurisdiction is simply not realistic.
- Consider the structure and duration of clinical placements to enable students to settle in and become part of the healthcare team. Considerations for longer and more in-depth placements ensure students are able to attain a sense of belonging and avoid being left in an observational mode. Optimising clinical placements is vital to enabling students to integrate theory into practice and build their confidence, which facilitates their transition from student to professional nurse.
- Standardise the assessment requirements and tools for all BN students in the off-campus clinical environment and provide appropriate training and ongoing support for clinical assessors in collaboration with the practice sector.

Practice Sector

- Develop meaningful collaboration and authentic partnerships with the education sector based on a shared sense of accountability that diminish the delineation of educational responsibilities between the education and practice sectors and acknowledge the notion that preparing graduate RNs is a shared and equal responsibility between both sectors.
- Offer undergraduate nursing students paid employment in healthcare to enable the attainment of **contextual enculturation** and to further develop their fundamental clinical skills as an adjunct to clinical placement.
- Optimise the learning culture in all clinical settings, as a matter of priority, to support all learners including students, graduate RNs and other clinicians to protect the growth of future generations of the profession. Supporting learners should not be considered an additional chore for clinicians and should not be left to chance based on the attitudes and leadership skills of local managers. Optimising the learning culture should be driven from the top of an organisation and trickle down into each and every clinical setting. Each clinician should understand how they can contribute to the professional development of learners as part of their professional role.
- Offer professional development opportunities to optimise clinicians' capability in the teaching role. Such opportunities should develop clinicians' knowledge and skills in the area of teaching, performance assessment, giving feedback and engaging in debriefing and reflective practice.

- Change the language used in reference to the graduate RN within the practice sector. The significance of using a different term such as ‘Intern’, which is used within the medical profession, is to ensure graduate RNs are identified by all clinicians as novices.
- Continue to offer structured transition programmes to support graduate RNs and enhance their transition experience.
- Collaborate with the education sector to align final year placements with graduate RN programmes to enable the attainment of **contextual enculturation**.
- Adopt roster management systems and staffing ratios that distinguish between novice and expert clinicians and acknowledge the developmental requirements of newly graduated RNs.

Suggestions for Further Research

As a result of the research findings offered in this thesis, it is recommended that further research be carried out in the following areas in order to:-

- Test the theory *Practice Readiness: A Nebulous Construct* from the perspective of other stakeholders and representatives of the education and practice sectors in Australia.
- Determine the appropriateness of the minimum of 800 hours of workplace experience that is currently required by the *Registered Nurse Accreditation Standards* (ANMAC 2012). This is important given that the professional opinion of participants in this study indicated that BN students are ought to

be offered more clinical hours for workplace experience than the current minimum of 800 hours as required by the *Registered Nurse Accreditation Standards* (ANMAC 2012).

- Measure the direct and indirect service contribution/provision of undergraduate nursing students during clinical placement in the acute hospital setting. The aim should be to quantify the costs and benefits to the host organisations and to inform the debate regarding the cost of clinical placements.
- Assess the factors that impact contextual enculturation at point of employment on the transition experiences of graduate RNs in varying clinical settings. The aim should be to determine the factors that strengthen and hinder contextual enculturation in any clinical setting such as critical care, mental health, paediatrics, community and others.
- Explore an innovative supervision model of undergraduate nursing students that take into consideration that not all clinicians make good preceptors (Altmann 2006), the rapid turnover of staff (Tuohy 2011) and the substantial number of junior staff working in part time capacity expected to fulfil the role of preceptors, the stressful demands of an often busy clinical environment due to high acuity and rapid turnover of patients (Borneuf & Haigh 2010; Tuohy 2011), and the varying assessment processes and requirements (Tuohy 2011).
- Explore factors that support and hinder the ability of undergraduate nursing students to develop a sense of belonging in the clinical setting and

to the nursing profession. The aim should be to identify best practice principles for application within the education and practice sectors.

- Explore why we continue to employ most graduates in acute hospitals first? As a profession, we need to pose such philosophical questions. This trend appears to continue despite the radical shift in healthcare delivery from acute to primary healthcare settings (WHO 1978, 2008) in response to the sharp global increase in prevalence of chronic diseases and the complex care needs of aging global populations (Betony 2012).
- Explore the benefits and pitfalls of graduate RNs transitioning in other clinical settings rather than the current practice where most graduates are expected to consolidate in acute hospital settings first before advancing to other clinical specialties.

Concluding Remarks

As this chapter brings the thesis to a conclusion, it offers the researcher an opportunity to reflect on her journey as a PhD candidate and on her professional growth as a person and a researcher. Like many PhD candidates, the researcher completed her dissertation while working at a full time capacity. Being a nurse educator within a large regional health service can be very demanding and rewarding at the same time. However, balancing the demands of a full time job and married life while undertaking a PhD was quite taxing for the researcher. The researcher experienced the highs and lows, and the ups and downs that are usually experienced by PhD candidates. Despite all the challenges encountered along the

way, the researcher feels that her PhD journey was a magical and life-changing experience. Coming into this PhD apprenticeship as a novice researcher, she used every opportunity to advance her knowledge and skills in the area of research and developed wide professional networks in her field of work and study at a local and national level. At this stage of her research journey, she has come to understand Glaser's (1998) assertion that a researcher needs to undertake Grounded Theory research to understand the methodology. By undertaking this national Grounded Theory study, the researcher believes she has now developed a much better understanding of Grounded Theory as a research methodology.

Chapter Summary

Given the forecasted shortage of nurses and increased demands on the nursing workforce, developing a better understanding of the perspectives of the practice and education sectors regarding new graduate RN practice readiness in the Australian context, is significant. Participant voices were presented extensively to acknowledge their expertise and to present the findings through their lens. The findings of this study have implications for professional nursing governing bodies, health policy makers and education and practice sectors. If considered by stakeholders, this new knowledge and the subsequent recommendations have the scope to enhance the transition experiences of newly graduated RNs and as such enhance their retention in the workforce. Additionally, this will translate to the delivery of cost effective, high quality healthcare in Australia.

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APPENDICES

Appendix 1: Information Sheet

Participant Information Sheet

Towards an understanding of practice readiness: the perspectives of nurse unit managers and Bachelor of Nursing programme coordinators regarding recently graduated registered nurses.

Principal Investigator: May El Haddad

Thank you for taking the time to read this information sheet and considering participating in this research.

As the name of the research topic indicates this research aims to understand your perspective regarding recently graduated registered nurses.

Who has approved the research?

This research is being conducted under the auspices of the University of Wollongong (UOW) and has been approved by the Human Research Ethics Committee.

What will be required if I participate?

Participation in this research is voluntary and you may leave the research at any stage and where possible, data will be withdrawn. Likewise it is your choice to participate or not.

By agreeing to be part of this research you will be invited to participate in an individual interview. This will take about an hour of your time but will happen at a time that is convenient to you.

How will confidentiality be maintained?

Should you mention your name or the name of a colleague during the interview, when that data is transcribed from tape to paper the names and any other personal identifiers will be removed so that comments cannot be attributed to an individual. The taped interviews will be kept as an electronic file on a CD stored in a locked filing cabinet or a password protected computer in the principal investigators' secured office. Only the principal investigator will have access to the taped recordings of the interviews.

Will I be informed of the results of the research?

I will send you a plain English summary of the findings if you indicate on the consent form that you wish to receive the summary. Your contributions to this research will inform my PhD thesis, journal articles and conference presentations.

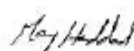
How do I participate in the research?

If you would like to participate in this research please complete the attached consent form and return it to me in the reply-paid envelope provided.

If you have any concerns about the way in which this research has been conducted please contact the Ethics Unit, Research Services Office, UOW on phone 0242213386 or email rso-ethics@uow.edu.au

Thank you for taking the time to read this information sheet. Please feel free to contact me if you would like to know more about the research at 07 54706833.

Regards,



May El Haddad RN, PhD (cand)

Appendix 2: Informed Consent

CONSENT FORM

Towards an understanding of practice readiness: the perspectives of nurse unit managers and Bachelor of Nursing programme coordinators regarding recently graduated registered nurses.

I.....

of (address/email).....

agree to participate in a research project explained to me by the researcher about recently graduated registered nurses.

I understand that:

- I am to participate in an individual interview, which will be taped
- My privacy will be protected. Any personal information that I provide will not be made public in any form that could reveal my identity to an outside party i.e. I remain anonymous
- I am free to withdraw my consent at any time during the project and my data will be withdrawn
- I have had the opportunity to discuss this project and I am satisfied with the answers I have been given
- I know who to contact if I have any questions about the research project
- I understand that my contribution will inform a PhD thesis and de-identified findings may be presented at conferences and/or within journal articles

.....
Date

.....
Signature of participant

Please indicate if you would like to receive a plain English summary of results when the study concludes. These will be sent to the above address.

Yes ☐

No ☐

Appendix 3: Confirmation of Ethical Clearance

Ethical clearance from CQUniversity

Secretary, Human Research Ethics Committee
Ph: 07 4923 2603
Fax: 07 4923 2600
Email: ethics@cqu.edu.au

8 June 2011

Ms May El Haddad
36 Grandview Lane
Coolumb Beach QLD 4573

Dear Ms El Haddad

HUMAN RESEARCH ETHICS COMMITTEE APPROVAL: PROJECT H11/05-090, *TOWARDS AN UNDERSTANDING OF PRACTICE READINESS: THE PERSPECTIVES OF NURSE UNIT MANAGERS AND BACHELOR OF NURSING PROGRAMME COORDINATORS REGARDING RECENTLY GRADUATED REGISTERED NURSES*

The Human Research Ethics Committee is an approved institutional ethics committee constituted in accord with guidelines formulated by the National Health and Medical Research Council (NHMRC) and governed by policies and procedures consistent with principles as contained in publications such as the joint Universities Australia and NHMRC *Australian Code for the Responsible Conduct of Research*. This is available at http://www.nhmrc.gov.au/publications/synopses/_files/r39.pdf.

On 31 May 2011, the committee met and considered your application. The project was assessed as being greater than low risk, as defined in the National Statement. The committee is pleased to tell you that they have granted approval for your research project *Towards an understanding of practice readiness: the perspectives of nurse unit managers and bachelor of Nursing programme coordinators regarding recently graduated registered nurses* (Project Number H11/05-090).

The period of ethics approval will be from 8 June 2011 above to 1 June 2012. The approval number is H11/05-090; please quote this number in all dealings with the Committee. HREC wishes you well with the undertaking of the project and looks forward to receiving the final report and statement of findings.

The standard conditions of approval for this research project are that:

- (a) you conduct the research project strictly in accordance with the proposal submitted and granted ethics approval, including any amendments required to be made to the proposal by the Human Research Ethics Committee;
- (b) you advise the Human Research Ethics Committee (email ethics@cqu.edu.au) immediately if any complaints are made, or expressions of concern are raised, or any other issue in relation to the project which may warrant review of ethics approval of the project. (A written report detailing the adverse occurrence or unforeseen event must be submitted to the Committee Chair within one working day after the event.)

- (c) you make submission to the Human Research Ethics Committee for approval of any proposed variations or modifications to the approved project before making any such changes;
- (d) you provide the Human Research Ethics Committee with a written "Annual Report" on each anniversary date of approval (for projects of greater than 12 months) and "Final Report" by no later than one (1) month after the approval expiry date, or upon submission of your thesis (Psychology honours students only) ; *(A copy of the reporting pro formas may be obtained from the Human Research Ethics Committee Secretary, Sue Evans please contact at the telephone or email given on the first page.)*
- (e) you accept that the Human Research Ethics Committee reserves the right to conduct scheduled or random inspections to confirm that the project is being conducted in accordance to its approval. Inspections may include asking questions of the research team, inspecting all consent documents and records and being guided through any physical experiments associated with the project
- (f) if the research project is discontinued, you advise the Committee in writing within five (5) working days of the discontinuation;
- (g) A copy of the Statement of Findings is provided to the Human Research Ethics Committee when it is forwarded to participants.

Please note that failure to comply with the conditions of approval and the *National Statement on Ethical Conduct in Human Research* may result in withdrawal of approval for the project.

In the event that you require an extension of ethics approval for this project, please make written application in advance of the end-date of this approval. The research cannot continue beyond the end date of approval unless the Committee has granted an extension of ethics approval. Extensions of approval cannot be granted retrospectively. Should you need an extension but not apply for this before the end-date of the approval then a full new application for approval must be submitted to the Secretary for the Committee to consider.

The Human Research Ethics Committee is committed to supporting researchers in achieving positive research outcomes through sound ethical research projects. If you have issues where the Human Research Ethics Committee may be of assistance or have any queries in relation to this approval please do not hesitate to contact the Ethics and Compliance Officer or myself.

Yours sincerely,

Dr Teresa Moore
Acting Chair, Human Research Ethics Committee

Cc: Associate Professor Lorna Moxham, Mr Marc Broadbent (Supervisors)
Project file

Application Category: A

Ethical clearance from UOW



RENEWAL APPROVAL
In reply please quote: HE12/356
Further Enquiries Phone: 4221 3386

28 August 2015

Ms May El Haddad
36 Grandview Lane
Coolum Beach QLD 4573

Dear Ms El Haddad,

Thank you for submitting the progress report. I am pleased to advise that renewal of the following Human Research Ethics application has been approved.

Ethics Number: HE12/356
Project Title: Towards an understanding of practice readiness: the perspectives of nurse unit managers and Bachelor of Nursing programme coordinators regarding recently graduated registered nurses
Researchers: Ms May El Haddad, Professor Lorna Moxham
Renewed From: 6 September 2015
New Expiry Date: 5 September 2016

Please note that approvals are granted for a twelve month period. Further extension will be considered on receipt of a progress report prior to the expiry date.

This certificate relates to the research protocol submitted in your original application and all approved amendments to date. Please remember that in addition to completing an annual report the Human Research Ethics Committee also requires that researchers immediately report:

- proposed changes to the protocol including changes to investigators involved
- serious or unexpected adverse effects on participants
- unforeseen events that might affect continued ethical acceptability of the project.

A condition of approval by the HREC is the submission of a progress report annually and a final report on completion of your project. The progress report template is available at <http://www.uow.edu.au/research/ethics/UOW009385.html>. This report must be completed, signed by the appropriate Head of School and returned to the Research Services Office prior to the expiry date.

If you have any queries regarding the HREC review process, please contact the Ethics Unit on phone 4221 3386 or email rso-ethics@uow.edu.au.

Yours sincerely,

Professor Colin Thomson
Chair, UOW & ISLHD Health and Medical
Human Research Ethics Committee

The University of Wollongong/Illawarra and Shoalhaven Local Health District Health and Medical HREC is constituted and functions in accordance with the NHMRC National Statement on Ethical Conduct in Human Research.

Ethics Unit, Research Services Office
University of Wollongong NSW 2522 Australia
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